State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

August 1, 2013

Barbara Houchin, Executive Director, Planning
Saint Thomas Health
102 Woodmont Blvd., Suite 800
Nashville, TN 37205

RE: Certificate of Need Application -- Seton Corporation d/b/a Saint Thomas Midtown Hospital f/k/a Baptist Hospital - CN1307-028

Dear Ms. Houchin:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the replacement and relocation of four operating rooms. The estimated project cost is $11,499,496.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on August 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 23, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

MMH:mab

cc: Dan Henderson, Director, Division of Health Statistics

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Health Services and Development Agency
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MEMORANDUM

TO: Dan Henderson, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: August 1, 2013

RE: Certificate of Need Application
Seton Corporation d/b/a Saint Thomas Midtown Hospital f/k/a Baptist Hospital - CN1307-028

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on August 1, 2013 and end on October 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: Barbara Houchin, Executive Director, Planning

2013 JUL 10 AM 9 46

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson County (County), Tennessee, on or before July 10 (Month / day), 2013 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Seton Corporation d/b/a Baptist Hospital (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Seton Corporation with an ownership type of not-for-profit

and to be managed by: Seton Corporation d/b/a Baptist Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the replacement and relocation of four operating rooms at Baptist Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Baptist Hospital will not change as a result of this project. Renovations will be made to 17,842 square feet of space and there will be no new construction. The total project costs are estimated to be $11,499,496.

The anticipated date of filing the application is: July 15, 2013

The contact person for this project is Barbara Houchin (Contact Name), Executive Director, Planning (Title)

who may be reached at: Saint Thomas Health (Company Name), 102 Woodmont Blvd., Suite 800 (Address)

Nashville (City), TN (State), 37205 (Zip Code), 615-284-6849 (Area Code / Phone Number)

Barbara Houchin (Signature), 7/9/2013 (Date), bhouchin@stthomas.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

2. Significant Accounting Policies (continued)

The provision for bad debt expense is based upon management's assessment of expected net collections considering economic conditions, historical experience, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for bad debt expense to establish an appropriate allowance for uncollectible accounts. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System. Accounts receivable are written off after collection efforts have been followed in accordance with the System's policies.

Impairment, Restructuring, and Nonrecurring Gains (Losses)

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on future discounted net cash flows or other estimates of fair value.

During the year ended June 30, 2012, the System recorded total impairment, restructuring and nonrecurring gains, net of $297,548. This amount was comprised primarily of pension curtailment gains of $414,294, as discussed in the Retirement Plans note, partially offset by long-lived asset impairments and restructuring charges of $61,151, and $55,595 of nonrecurring expenses associated with Symphony.

For the year ended June 30, 2011, the System recorded total impairment, restructuring and nonrecurring losses, net of $92,387, comprised of long-lived asset impairments of approximately $21,834 and restructuring and nonrecurring expenses of approximately $70,553. The restructuring and nonrecurring expenses for the year ended June 30, 2011, included approximately $44,355 of nonrecurring expenses associated with Symphony. Symphony nonrecurring expenses include project management and process reengineering costs, as well as costs to establish a shared service center and develop a business intelligence data warehouse.

2. Significant Accounting Policies (continued)

Amortization

Bond issuance costs, discounts, and premiums are amortized over the term of the bonds using a method approximating the effective interest method.

Income Taxes

The member healthcare entities of Ascension Health Alliance are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) or Section 501(c)(2), and their related income is exempt from federal income tax under Section 501(a).

Regulatory Compliance

Various federal and state agencies have initiated investigations regarding reimbursement claimed by certain members of the System. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of the investigations will not have a material adverse impact on the consolidated financial statements of Ascension Health Alliance.

Reclassifications

Certain reclassifications were made to the 2011 accompanying consolidated financial statements to conform to the 2012 presentation.

Subsequent Events

The System evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the consolidated financial statements are issued, for potential recognition in the consolidated financial statements as of the balance sheet date. For the year ended June 30, 2012, the System evaluated subsequent events through September 12, 2012, representing the date on which the accompanying audited consolidated financial statements were issued. During this period, there were no material subsequent events that required recognition or disclosure in the accompanying consolidated financial statements.

3. Organizational Changes

Business Combinations

Effective January 1, 2012, Ascension Health, a subsidiary of Ascension Health Alliance, became sole corporate member of Alexian Brothers Health System (Alexian Brothers), a Catholic healthcare system that operates acute and specialty care hospitals, ambulatory care clinics, physician practices and senior living facilities in Illinois, Missouri, Tennessee, and Wisconsin. This transaction resulted in a net increase to unrestricted net assets of $326,333, reflected as contributions from business combinations in the Consolidated Statement of Operations and Changes in Net Assets during the year ended June 30, 2012. Furthermore, this addition resulted in a contribution of restricted net assets of $16,337, included in other changes in net assets in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2012.

Pooled Investment Fund

For the year ended June 30, 2011, and prior to April 2012, the System held a significant portion of its investments in the Ascension Legacy Portfolio, an investment pool of funds in which the System and a limited number of nonprofit healthcare providers participated. In April 2012, a significant portion of the assets in the Ascension Legacy Portfolio was transferred to the Alpha Fund, a separate legal entity created during the year ended June 30, 2012. Certain System assets continue to be held through the Ascension Legacy Portfolio, and subsequent to April 2012, the Ascension Legacy Portfolio no longer holds assets for unrelated entities.

Prior to April 2012, CHIMCO, a wholly owned subsidiary of Ascension Health Alliance, managed the investment portfolio of Ascension Health Alliance held in the Ascension Legacy Portfolio. CHIMCO provides expertise in the areas of asset allocation, selection and monitoring of outside investment managers, and risk management. The System did not consolidate the Ascension Legacy Portfolio prior to April 2012. Accordingly, the System's investments recorded in the consolidated financial statements consisted only of the System's pro-rata share of the Ascension Legacy Portfolio's investments held for participants prior to April 2012.

The Alpha Fund includes the investment interests of Ascension Health Alliance and other Alpha Fund members. CHIMCO manages and serves as the manager and primary investment advisor of the Alpha Fund, overseeing the investment strategies offered to the Alpha Fund's members. Ascension Health Alliance began consolidating the Alpha Fund in April 2012.

3. Organizational Changes (continued)

The portion of the Alpha Fund's net assets representing interests held by entities other than Ascension Health Alliance are reflected in noncontrolling interests in the Consolidated Balance Sheet at June 30, 2012, which amount to $589,493 at June 30, 2012.

The consolidation of the Alpha Fund by the System in April 2012 resulted in an increase of net assets of $440,015, representing the noncontrolling interests of the Alpha Fund as of the date investments were transferred into the Alpha Fund. Additional information about the Alpha Fund is included in the Pooled Investment Fund note.

Divestitures and Discontinued Operations

Effective October 1, 2011, Seton Health System, Inc. (Seton Health) in Troy, New York, separated from the System and became part of a newly formed nonprofit healthcare organization that operates in the state of New York. The operations of Seton Health are reflected in the System's consolidated financial statements as discontinued operations.

Ascension Health Alliance reported a decrease in net assets from discontinued operations of $54,998 for the year ended June 30, 2012, representing the contribution of net assets related to the separation of Seton Health and the deficit of revenues over expenses for previously discontinued lines of business in Michigan. These entities had recorded operating revenues totaling $39,659 during the period that they were operational during the year ended June 30, 2012.

Ascension Health Alliance reported an increase in net assets from discontinued operations of $19,421 for the year ended June 30, 2011, representing the excess of revenues over expenses for previously discontinued lines of business in Michigan, New York, and Tennessee. These entities had recorded operating revenues totaling $186,902 during the period that they were operational during the year ended June 30, 2011.

Other

In March 2012, Ascension Health Alliance and Daughters of Charity Health System (DCHS) entered into a non-binding memorandum of understanding to explore having DCHS join Ascension Health, a subsidiary of Ascension Health Alliance. Completion of the proposed transaction is subject to the execution of final agreements and obtaining all necessary approvals.

3. Organizational Changes (continued)

In June 2012, Ascension Health Alliance and Marian Health System, Inc. (Marian) entered into a non-binding memorandum of understanding to explore having Marian join Ascension Health Alliance. Completion of the proposed transaction is subject to the execution of final agreements and obtaining all necessary approvals.

4. Pooled Investment Fund

As discussed in the Organizational Changes note, in April 2012, substantially all of the System's investments previously held in the Ascension Legacy Portfolio were transferred to the Alpha Fund, in which Ascension Health Alliance and certain other entities are members. At June 30, 2012, a significant portion of the System's investments consist of Ascension Health Alliance's interest in the Alpha Fund.

The Alpha Fund invests in a diversified portfolio of investments including alternative investments, such as real asset funds, hedge funds, private equity funds, commodity funds and private credit funds. Collectively, these funds have liquidity terms ranging from weekly to annual with notice periods ranging from 1 to 93 days. Due to redemption restrictions, investments in certain of these funds, whose fair value was approximately $683,000 at June 30, 2012, cannot currently be redeemed. However, the potential for the Alpha Fund to sell its interest in these funds in a secondary market prior to the end of the fund term does exist.

The Alpha Fund's investments in certain alternative investment funds also include contractual commitments to provide capital contributions during the investment period which is typically five years and can extend to the end of the fund term. During these contractual periods, investment managers may require the Alpha Fund to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2012, contractual agreements of the Alpha Fund expire between July 1, 2012 and March 31, 2018. The remaining unfunded capital commitments of the Alpha Fund total approximately $729 million for 51 individual funds as of June 30, 2012. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by the liquidation of existing investments in the Alpha Fund.

In the normal course of operations and within established Alpha Fund guidelines, the Alpha Fund may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, option and forward contracts as well as warrants and swaps.

4. Pooled Investment Fund (continued)

These instruments are used primarily to adjust the portfolio duration, restructure term structure exposure, change sector exposure, and arbitrage market inefficiencies. See the Fair Value Measurements note for a discussion of how fair value for the Alpha Fund's derivatives is determined.

At June 30, 2012, the notional value of Alpha Fund derivatives outstanding was approximately $2,071,000. The fair value of Alpha Fund derivatives in an asset position was $71,936 at June 30, 2012, while the fair value of Alpha Fund derivatives in a liability position was $36,266 at June 30, 2012. These derivatives are included in long-term investments in the Consolidated Balance Sheet at June 30, 2012.

The Alpha Fund also participates in a securities lending program, whereby a portion of the Alpha Fund's investments are loaned to selected established brokerage firms in return for cash and securities from the brokers as collateral for the investments loaned, usually on a short-term basis. The fair value of collateral held by the Alpha Fund associated with such lending agreements amounts to approximately $320,000 and is included in other current assets in the Consolidated Balance Sheet at June 30, 2012, while the liability associated with the obligation to repay such collateral is also approximately $320,000, and is included in other current liabilities in the Consolidated Balance Sheet at June 30, 2012. In addition, the Alpha Fund has liabilities for investments sold, not yet purchased, representing obligations of the Alpha Fund to purchase investments in the market at prevailing prices. The fair value of this Alpha Fund liability is approximately $160,000 and is included in other noncurrent liabilities in the Consolidated Balance Sheet at June 30, 2012.

Due from brokers and due to brokers on the Consolidated Balance Sheet at June 30, 2012, represent the Alpha Fund's positions and amounts due from or to various brokers, primarily amounts for security transactions not yet settled, as well as cash held by brokers for securities sold, not yet purchased.

(Dollars in Thousands)

5. Cash and Investments

The System's cash and investments are reported in the June 30, 2012, Consolidated Balance Sheet as presented in the table that follows. Total cash and investments, net, includes both the System's membership interest in the Alpha Fund as well as the noncontrolling interests held by other Alpha Fund members. System unrestricted cash and investments, net, represent the System's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30, 2012
Cash and cash equivalents	$ 306,469
Short-term investments	216,914
Long-term investments	10,468,457
Subtotal	10,991,840
Other Alpha Fund and Ascension Legacy Portfolio assets and liabilities:	
In other current assets	360,999
In other long-term assets	2,924
In accounts payable and accrued liabilities	(12,779)
In other current liabilities	(322,873)
In other noncurrent liabilities	(157,073)
Due from (to) brokers, net	(91,342)
Total cash and investments, net	10,771,696
Less noncontrolling interests of Alpha Fund	589,493
System cash and investments, including assets limited as to use	10,182,203
Less assets limited as to use	1,064,385
System unrestricted cash and investments, net	$ 9,117,818

(Dollars in Thousands)

5. Cash and Investments (continued)

At June 30, 2012, the composition of cash and cash equivalents, short-term investments and long-term investments, which include certain assets limited as to use, is summarized as follows.

	June 30, 2012
Cash and cash equivalents and short-term investments	$ 498,902
Pooled short-term investment funds	416,087
U.S. government, state, municipal and agency obligations	3,271,474
Corporate and foreign fixed income securities	980,322
Asset-backed securities	1,057,735
Equity securities	1,574,188
Private equity, alternative investments and other investments	3,193,132
Total cash and cash equivalents, short-term investments and long-term investments	$ 10,991,840

At June 30, 2011, the System's investments consisted of its pro rata share of the Ascension Legacy Portfolio's funds held for participants and certain other investments such as those investments held and managed by foundations. The System's June 30, 2011 investments are reported in the accompanying Consolidated Balance Sheet as presented in the table that follows. Assets limited as to use are discussed in the Short-Term Investments and Long-Term Investments and Investment Return sections of the Significant Accounting Policies note. Long-term investments include investments designated for a specific purpose by resolution of the System Board or local Health Ministry Boards which were approximately $601,000 at June 30, 2011.

	June 30, 2011
Cash and cash equivalents	$ 1,107,846
Short-term investments	237,461
Long-term investments	8,117,951
System cash and investments	9,463,258
Less assets limited as to use	994,297
System unrestricted cash and investments	$ 8,468,961

(Dollars in Thousands)

5. Cash and Investments (continued)

At June 30, 2011, the composition of cash and investments classified as cash and cash equivalents, short-term investments, assets limited as to use and other long-term investments is summarized as follows:

	June 30, 2011
Cash and cash equivalents	$ 450,436
Short-term investments	60,559
U.S. government, state, municipal and agency obligations	49,958
Corporate and foreign fixed income securities	50,762
Asset-backed securities	60,280
Equity securities	314,672
Private equity and other investments	164,895
Subtotal, included in cash and cash equivalents, short-term investments, and long-term investments	1,151,562
Ascension Health Alliance's pro rata share of Ascension Legacy Portfolio funds held for participants	8,311,696
Total cash and cash equivalents, short-term investments and long-term investments	$ 9,463,258

The System's pro rata share of the Ascension Legacy Portfolio's funds held for participants was $8,311,696 at June 30, 2011, representing approximately 76.6% of the funds held for participants in the Ascension Legacy Portfolio.

(Dollars in Thousands)

5. Cash and Investments (continued)

The following is a condensed balance sheet of the Ascension Legacy Portfolio at June 30, 2011, including the interests of the System and all other participating entities:

	June 30, 2011
Assets	
Cash	$ 26,757
Loans, interest, and other receivables	88,180
Due from brokers	799,869
Securities lending collateral	378,877
Derivative asset	33,208
Investments, at fair value:	
Short-term investments	747,955
U.S. government obligations	3,056,988
Corporate and foreign fixed income securities	1,260,685
Asset-backed securities	1,764,404
Equity, private equity, and other investments	2,287,580
Equity method investments	2,026,142
Total assets	$ 12,470,645
Liabilities and funds held for participants	
Due to brokers	$ 1,032,350
Derivative liability	34,768
Investments sold, not yet purchased	166,663
Other payables	6,743
Payable under securities lending program	380,684
Total liabilities	1,621,208
Funds held for participants	10,849,437
Total liabilities and funds held for participants	$ 12,470,645

(Dollars in Thousands)

5. Cash and Investments (continued)

Net investments under CHIMCO management and held in the Ascension Legacy Portfolio at March 31, 2012, yet not included in the Alpha Fund or the Ascension Legacy Portfolio while still managed by CHIMCO at April 1, 2012, were approximately $1,820,000. As of June 30, 2012, the System's membership interest in the Alpha Fund as well as the noncontrolling interest (see Note 2) in the Alpha Fund, representing interests held by entities other than Ascension Health Alliance, total $8,840,551 and $589,493, respectively.

Investment return recognized by the System for the years ended June 30, 2012 and 2011, is summarized in the following table. Total investment return includes the System's return in the Ascension Legacy Portfolio as well as the investment return of the Alpha Fund. System investment return represents the System's total investment return, net of the investment return earned by the noncontrolling interests of other Alpha Fund members.

	Year Ended June 30, 2012	2011
Investment return in Ascension Legacy Portfolio	**$ 57,921**	$ 1,142,327
Interest and dividends	**51,453**	17,001
Net losses on investments reported at fair value	**(233,826)**	80,409
Restricted investment income	**3,386**	6,163
Total investment return	**(121,066)**	1,245,900
Less return earned by noncontrolling interests of Alpha Fund	**(9,264)**	–
System investment return	**$ (111,802)**	$ 1,245,900

6. Fair Value Measurements

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available in the circumstances.

6. Fair Value Measurements (continued)

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The System follows the three-level fair value hierarchy to categorize these assets and liabilities recognized at fair value at each reporting period, which prioritizes the inputs used to measure such fair values. Level inputs are defined as follows:

Level 1 – Quoted prices (unadjusted) that are readily available in active markets or exchanges for identical assets or liabilities on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 pricing inputs include prices quoted for similar assets and liabilities in active markets or exchanges or prices quoted for identical or similar assets and liabilities in markets that are not active. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Significant pricing inputs that are unobservable for the asset or liability, including assets or liabilities for which there is little, if any market activity for such asset or liability. Inputs to the determination of fair value for Level 3 assets and liabilities require management judgment and estimation.

As of June 30, 2012 and 2011, the Level 2 and Level 3 assets and liabilities listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

Cash and cash equivalents and short-term investments

Cash and cash equivalents and certain short-term investments include certificates of deposit, whose fair value is based on cost plus accrued interest. Significant observable inputs include security cost, maturity, and relevant short-term interest rates. Other short-term investments designated as Level 2 investments primarily consist of commercial paper, whose fair value is based on the income approach. Significant observable inputs include security cost, maturity, and credit rating, interest rate and par value.

6. Fair Value Measurements (continued)

U. S. government, state, municipal and agency obligations

The fair value of investments in U.S. government, state, municipal and agency obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

Corporate and foreign fixed income securities

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

Asset-backed securities

The fair value of U.S. agency and corporate asset-backed securities is primarily determined using techniques consistent with the income approach. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

Equity securities

The fair value of investments in U.S. and international equity securities is primarily determined using techniques consistent with the income approach. The values for underlying investments are fair value estimates determined by external fund managers based on quoted market prices, operating results, balance sheet stability, growth, dividend, dividend yield, and other business and market sector fundamentals.

6. Fair Value Measurements (continued)

Private equity, alternative investments and other investments

The fair value of private equity investments is primarily determined using techniques consistent with both the market and income approaches, based on the System's estimates and assumptions in the absence of observable market data. The market approach considers comparable company, comparable transaction, and company-specific information, including but not limited to restrictions on disposition, subsequent purchases of the same or similar securities by other investors, pending mergers or acquisitions, and current financial position and operating results. The income approach considers the projected operating performance of the portfolio company.

Alternative investments consist of hedge funds, private equity funds, commodity funds, and real estate partnerships. Alternative investments are valued using net asset values, which approximate fair value, as determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth and other business and market sector fundamentals.

Other investments include derivative assets and derivative liabilities of the Alpha Fund, whose fair value is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity and recovery rates.

Securities lending collateral

The fair value of collateral received under the Alpha Fund's securities lending program is valued using the calculated net asset value for the commingled fund in which the collateral is invested. The underlying investments in the commingled fund are valued using techniques consistent with the market approach, which uses significant observable market inputs such as available trade, quotes, benchmark curves, sector groupings, and matrix pricing.

Benefit plan assets

The fair value of benefit plan assets is based on original investment into a guaranteed pooled fund, plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

(Dollars in Thousands)

6. Fair Value Measurements (continued)

Interest rate swap assets and liabilities

The fair value of interest rate swaps is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Investments sold, not yet purchased

The fair value of investments sold, not yet purchased is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark, constant maturity curves, and spreads.

The following table summarizes fair value measurements, by level, at June 30, 2012, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2012				
Cash and cash equivalents	$ 78,301	$ 3,419	$ –	$ 81,720
Short-term investments	14,567	79,321	–	93,888
Pooled short-term investment funds	416,087	–	–	416,087
U.S. government, state, municipal and agency obligations	–	3,264,037	7,437	3,271,474
Corporate and foreign fixed income securities	–	859,904	120,418	980,322
Asset-backed securities	–	1,042,438	15,297	1,057,735
Equity securities	1,546,579	14,491	13,118	1,574,188
Private equity, alternative investments and other investments	8,699	3,327	3,096,973	3,108,999
Assets not at fair value				407,427
Cash and investments				$ 10,991,840
Securities lending collateral, in other current assets	$ –	$ 321,937	$ –	$ 321,937
Benefit plan assets, in other noncurrent assets	136,435	–	36,932	173,367
Interest rate swaps, in other noncurrent assets	–	94,082	–	94,082
Investments sold, not yet purchased, in other noncurrent liabilities	–	157,073	–	157,073
Interest rate swaps, included in other noncurrent liabilities	–	248,511	–	248,511

(Dollars in Thousands)

6. Fair Value Measurements (continued)

For the year ended June 30, 2012, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following. Level 3 investments of the Alpha Fund are included in transfers in the table below.

	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity, Alternative Investments and Other Investments	Benefit Plan Assets
June 30, 2012						
Beginning balance	$ 442	$ 5,024	$ 1,924	$ 15,515	$ 86,166	$ 31,795
Total realized and unrealized gains (losses):						
Included in income from operations	21	192	(7)	886	(391)	–
Included in nonoperating gains (losses)	6	904	(149)	(69)	(33,994)	–
Included in changes in net assets	–	–	–	–	1,290	20
Purchases	–	77,943	2,919	–	458,171	8,716
Settlements	–	–	–	–	–	(91)
Issuances	–	–	–	–	–	35
Sales	–	(57,768)	(2,700)	(3,588)	(90,500)	(5,408)
Transfers into Level 3	6,968	94,201	15,012	374	2,676,231	2,649
Transfers out of Level 3	–	(78)	(1,702)	–	–	(784)
Ending balance	$ 7,437	$ 120,418	$ 15,297	$ 13,118	$ 3,096,973	$ 36,932

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

As discussed in the Organizational Changes and Pooled Investment Fund notes, the System recognized its pro rata share of the Ascension Legacy Portfolio's investments held for participants in the Consolidated Balance Sheet at June 30, 2011, which represented 76.6% of the net asset value of the Ascension Legacy Portfolio as of June 30, 2011. The Ascension Legacy Portfolio's investments at June 30, 2011, included equities, various fixed income securities, and alternative investments.

(Dollars in Thousands)

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2011, for Ascension Legacy Portfolio's financial assets and liabilities, measured at fair value on a recurring basis in Ascension Legacy Portfolio's financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2011				
Assets included in:				
Securities lending collateral	$ –	$ 378,877	$ –	$ 378,877
Derivative asset	19,649	2,303	11,256	33,208
Short-term investments	689,742	58,213	–	747,955
U.S. government obligations	–	3,046,822	10,166	3,056,988
Corporate and foreign fixed income securities	–	1,144,643	116,042	1,260,685
Asset-backed securities	–	1,719,704	44,700	1,764,404
Equity, private equity, and other investments	2,240,360	–	47,220	2,287,580
Liabilities included in:				
Derivative liability	1,162	3,116	30,490	34,768
Investments sold, not yet purchased	–	166,663	–	166,663

(Dollars in Thousands)

6. Fair Value Measurements (continued)

For the year ended June 30, 2011, the changes in the fair value of Ascension Legacy Portfolio's assets measured using significant unobservable inputs (Level 3) consisted of the following:

	U.S. Government Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity, Private Equity, and Other Investments	Net Derivatives
June 30, 2011					
Beginning balance	$ 7,340	$ 167,473	$ 26,069	$ 423,575	$ (40,449)
Total realized and unrealized gains included in nonoperating gains (losses)	202	8,209	1,514	99,730	180,214
Purchases, issuances, and settlements	1,199	(42,171)	19,814	(476,085)	(158,999)
Transfers into (out of) Level 3	1,425	(17,469)	(2,697)	–	–
Ending balance	$ 10,166	$ 116,042	$ 44,700	$ 47,220	$ (19,234)
The amount of total gains (losses) for the period included in nonoperating gains (losses) attributable to the change in unrealized gains or losses relating to assets still held at June 30, 2011	$ 107	$ (1,948)	$ 781	$ 5,872	$ (146,992)

(Dollars in Thousands)

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2011, for all other financial assets and liabilities, measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2011				
Cash and cash equivalents	$ 86,946	$ 6,954	$ –	$ 93,900
Short-term investments	15,592	44,768	–	60,360
U.S. government, state, municipal and agency obligations	–	49,516	442	49,958
Corporate and foreign fixed income securities	–	45,738	5,024	50,762
Asset-backed securities	–	58,356	1,924	60,280
Equity securities	284,701	14,456	15,515	314,672
Private equity, alternative investments and other investments	594	3,423	86,166	90,183
Assets not at fair value				431,447
Cash and investments				$ 1,151,562
Benefit plan assets, in other noncurrent assets	$ 137,391	$ –	$ 31,795	$ 169,186
Interest rate swaps, included in other noncurrent assets	–	64,426	–	64,426
Interest rate swaps, included in other noncurrent liabilities	–	141,287	–	141,287

(Dollars in Thousands)

6. Fair Value Measurements (continued)

During the year ended June 30, 2011, the changes in the fair value of the foregoing assets measured using significant unobservable inputs (Level 3) consisted of the following:

	U.S. Government, State, Municipal and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity, Alternative Investments and Other Investments	Benefit Plan Assets
June 30, 2011						
Beginning balance	$ 442	$ 4,845	$ 189	$ 6,164	$ 68,171	$ 28,369
Total realized and unrealized gains (losses):						
Included in income from operations	–	412	(16)	231	445	–
Included in nonoperating gains (losses)	–	–	–	–	(73)	–
Included in changes in net assets	–	–	–	–	315	–
Purchases, issuances, and settlements	–	(233)	1,463	9,120	18,373	2,611
Transfers into (out of) Level 3	–	–	288	–	(1,065)	815
Ending balance	$ 442	$ 5,024	$ 1,924	$ 15,515	$ 86,166	$ 31,795

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

7. Significant Investments in Unconsolidated Entities

The System has a 50% membership interest in Via Christi Health, Inc. (VCH). The System accounts for this membership interest under the equity method of accounting. The System's investment in VCH is $493,105 and $499,910 at June 30, 2012 and 2011, respectively, and is reported in the Consolidated Balance Sheets in investment in unconsolidated entities. The System's investment in VCH reflects the financial performance of VCH one month in arrears.

At June 30, 2012 and 2011, the difference between the amount at which the System's investment in VCH is carried in the accompanying Consolidated Balance Sheets and its interest in the underlying net assets of VCH is $30,321 and $30,568, respectively. This difference relates primarily to the excess of the fair value of VCH property and equipment and long-term debt over their carrying values at the date the System received the interest in VCH. The difference is being amortized over the remaining life of the property and equipment and term of the long-term debt.

(Dollars in Thousands)

7. Significant Investments in Unconsolidated Entities (continued)

Condensed financial information of VCH as of and for the years ended June 30, 2012 and 2011, is summarized below:

	June 30, 2012	2011
Current assets	**$ 752,074**	$ 748,221
Noncurrent assets	**954,184**	932,313
Total assets	**$ 1,706,258**	$ 1,680,534
Current liabilities	**$ 131,366**	$ 120,335
Noncurrent liabilities	**581,391**	555,415
Total liabilities	**712,757**	675,750
Net assets	**993,501**	1,004,784
Total liabilities and net assets	**$ 1,706,258**	$ 1,680,534
Total revenues	**$ 1,096,449**	$ 1,094,925
Total expenses	**(1,063,364)**	(1,072,680)
Total investment return	**(16,482)**	97,573
Excess of revenues over expenses	**$ 16,603**	$ 119,818

(Dollars in Thousands)

8. Long-Term Debt

Long-term debt at June 30, 2012 and 2011, is comprised of the following, and is presented in accordance with the specific master trust indenture to which the debt relates. As further discussed below, certain portions of long-term debt are secured under the Alexian Brothers Health System Master Trust Indenture.

	June 30, 2012	June 30, 2011
Tax-exempt hospital revenue bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Variable rate demand bonds, subject to a put provision that provides for a cumulative 7-month notice and remarketing period, payable through November 2047; interest (0.27% at June 30, 2012) tied to a market index plus a spread	$ 308,605	$ 320,480
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2039; interest (0.15% to 0.16% at June 30, 2012) set at prevailing market rates	225,665	246,730
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2033; interest (0.15% to 0.16% at June 30, 2012) set at prevailing market rates, swapped to fixed rates of 5.454 and 5.544% through maturity	307,300	150,325
Indexed put bonds subject to weekly rate resets based on a taxable index, payable through November 2046, interest (1.505% at June 30, 2012) swapped to a variable rate tied to a tax-exempt market index plus a spread through November 2016	153,800	153,800
Fixed rate put bonds (converted from an indexed put bond mode based on a taxable index in May 2009) payable through November 2046, interest (4.10% at June 30, 2012) swapped to a variable rate tied to a market index plus a spread through November 2016	153,690	153,690
Fixed rate serial and term bonds payable in installments through November 2051; interest at 4.125% to 5.75%	1,308,105	984,635
Fixed rate serial and term bonds payable in installments through November 2039; interest at 5.00% swapped to variable rates over the life of the bonds	587,360	599,490
Fixed rate serial mode bonds payable through 2047 with purchase dates ranging from April 2013 through May 2018; interest at 0.90% to 5.00% through the purchase dates	904,185	823,560
Fixed rate serial mode bonds payable through 2033 with purchase dates through May 2012; interest at 1.25%, swapped to fixed rates of 5.454% to 5.544% through maturity	–	156,975

(Dollars in Thousands)

8. Long-Term Debt (continued)

	June 30, 2012	2011
Tax-exempt hospital revenue bonds – unsecured under Ascension Health Alliance Subordinate Master Trust Indenture:		
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2027; interest (0.16% at June 30, 2012) set at prevailing market rates	**$ 56,060**	$ 57,815
Fixed rate serial mode bonds payable through 2027 with purchase dates through November 2012; interest at 5.00%, swapped to variable mode through the purchase dates	**49,810**	149,470
Fixed rate serial mode bonds payable through 2027 with purchase dates through May 2018; interest at 1.50% to 5.00%	**396,705**	303,270
Total hospital revenue bonds under Senior Master Trust Indenture and Subordinate Master Trust Indenture	**4,451,285**	4,100,240
Tax-exempt hospital revenue bonds – secured under Alexian Brothers Health System Master Trust Indenture:		
Fixed rate term bonds payable in installments through February 2038; interest at 3.50% to 5.50%	**161,565**	–
Total hospital revenue bonds under the Alexian Brothers Health System Master Trust Indenture	**161,565**	–
Total hospital revenue bonds under the Ascension Health Alliance Senior Master Trust Indenture, Ascension Health Alliance Subordinate Master Trust Indenture, and the Alexian Brothers Health System Master Trust Indenture	**4,612,850**	4,100,240
Other debt:		
Obligations under capital leases	**33,221**	34,865
Other	**37,936**	36,960
	4,684,007	4,172,065
Unamortized premium, net	**111,187**	67,233
Less current portion	**(45,363)**	(29,563)
Less long-term debt subject to short-term remarketing arrangements	**(1,094,425)**	(1,662,950)
Long-term debt, less current portion and long-term debt subject to short-term remarketing arrangements	**$ 3,655,406**	$ 2,546,785

(Dollars in Thousands)

8. Long-Term Debt (continued)

	June 30, 2012	2011
Ascension Health Alliance Senior Master Trust Indenture long-term debt obligations, including unamortized premium, net	$ 2,919,702	$ 1,953,354
Ascension Health Alliance Subordinate Master Trust Indenture long-term debt obligations, including unamortized premium, net	515,278	528,917
Alexian Brothers Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	167,257	–
Other	53,169	64,514
Long-term debt, less current portion, and long-term debt subject to short-term remarketing arrangements	$ 3,655,406	$ 2,546,785

Scheduled principal repayments of long-term debt, considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, as of June 30, 2012, are as follows:

	Ascension Health Alliance MTIs	Alexian Brothers Health System MTI	Other Debt	Total
Year ending June 30:				
2013	$ 22,810	$ 4,565	$ 17,989	$ 45,364
2014	57,785	3,290	5,978	67,053
2015	61,180	340	5,072	66,592
2016	51,650	7,485	2,787	61,922
2017	67,620	13,130	15,853	96,603
Thereafter	4,190,240	132,755	23,479	4,346,474
Total	$ 4,451,285	$ 161,565	$ 71,158	$ 4,684,008

The carrying amounts of variable rate bonds and other notes payable approximate fair value. The fair values of the unsecured fixed rate serial and term bonds are estimated based on discounted cash flow analyses that consider current incremental borrowing rates for similar types of borrowing arrangements. The fair value of both Ascension Health Alliance and Alexian Brothers fixed rate serial and term bonds, including the component of variable rate demand bonds subject to long-term fixed interest rates, approximates carrying value at June 30, 2012 and 2011. During the years ended June 30, 2012 and 2011, interest paid was approximately $148,300 and $146,000, respectively. Capitalized interest was approximately $2,000 and $7,100 for the years ended June 30, 2012 and 2011, respectively.

8. Long-Term Debt (continued)

Certain members of Ascension Health Alliance formed the Ascension Health Alliance Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member, a senior designated affiliate or a senior limited designated affiliate. Senior obligated group members are jointly and severally liable under a Senior Master Trust Indenture (Senior MTI) to make all payments required with respect to obligations under the Senior MTI and may be entities not controlled directly or indirectly by Ascension Health Alliance. Senior designated affiliates and senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI. Ascension Health Alliance may cause each senior designated affiliate to transfer such amounts as are necessary to enable the obligated group to comply with the terms of the Senior MTI, including payment of the outstanding obligations. Additionally, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with Ascension Health Alliance with stipulated repayment terms and conditions, each subject to the governing law of the senior limited designated affiliate's state of incorporation.

Pursuant to a Supplemental Master Indenture dated February 1, 2005, senior obligated group members, which are operating entities, have pledged and assigned to the Master Trustee a security interest in all of their rights, title, and interest in their pledged revenues and proceeds thereof.

A Subordinate Credit Group, which is comprised of subordinate obligated group members, subordinate designated affiliates, and subordinate limited designated affiliates, was created under the Subordinate Master Trust Indenture (Subordinate MTI). The subordinate obligated group members are jointly and severally liable under the Subordinate MTI to make all payments required with respect to obligations under the Subordinate MTI and may be entities not controlled directly or indirectly by Ascension Health Alliance. Subordinate designated affiliates and subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI. Ascension Health Alliance may cause each subordinate designated affiliate to transfer such amounts as are necessary to enable the obligated group members to comply with the terms of the Subordinate MTI, including payment of the outstanding obligations. Additionally, each subordinate limited designated affiliate has an independent subordinate limited designated affiliate agreement and promissory note with Ascension Health Alliance, with stipulated repayment terms and conditions, each subject to the governing law of the subordinate limited designated affiliate's state of incorporation.

8. Long-Term Debt (continued)

The unsecured variable rate demand bonds of both the Senior and Subordinate Credit Groups, while subject to long-term amortization periods, may be put to Ascension Health Alliance at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after June 30, 2012, the principal amount of such bonds has been classified as a current liability in the accompanying Consolidated Balance Sheets. Management believes the likelihood of a material amount of bonds being put to Ascension Health Alliance to be remote. However, to address this possibility, management has taken steps to provide various sources of liquidity in the event any bonds would be put, including the line of credit, commercial paper program, and maintaining unrestricted assets as a source of self-liquidity.

On January 1, 2012, Alexian Brothers became part of Ascension Health Alliance. Subsequently, Ascension Health Alliance redeemed or refinanced a portion of Alexian Brothers' debt; however, a portion of the bonds previously issued for the benefit of Alexian Brothers remains outstanding (the Alexian Brothers' Bonds). The Alexian Brothers' Bonds continue to be secured by the Alexian Brothers Health System Master Trust Indenture (As Amended and Restated), dated October 1, 1992, between the Members of the Alexian Brothers Health System Obligated Group established under this document and the Alexian Brothers Health System Master Trustee.

In May 2012, Ascension Health Alliance issued a total of $435,370 of tax-exempt bonds, Series 2012A through 2012E, through four different issuing authorities in four different states. The proceeds of the bonds, including original issue premium, were used to reimburse Ascension Health Alliance for previous capital expenditures.

Due to aggregate financing activity during the fiscal years ended June 30, 2012 and 2011, losses on extinguishment of debt of $2,828 and $1,007 were recorded, which are included in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

Ascension Health Alliance is a party to multiple interest rate swap agreements that convert the variable or fixed rates of certain debt issues to fixed or variable rates, respectively. See the Derivative Instruments note for a discussion of these derivatives.

8. Long-Term Debt (continued)

As of June 30, 2012, the Senior Credit Group has a line of credit of $1,000,000 which may be used as a source of funding for unremarketed variable debt (including commercial paper) or for general corporate purposes, towards which bank commitments totaling $1,000,000 extend to November 9, 2014. As of June 30, 2012 and 2011, there were no borrowings under the line of credit.

As of June 30, 2012, the Subordinate Credit Group has a $50,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $50,000 extends to December 27, 2012. The revolving line of credit may be accessed solely in the form of Letters of Credit issued by the bank for the benefit of the members of the Credit Groups. Of this $50,000 revolving line of credit, letters of credit totaling $26,067 have been issued as of June 30, 2012. No borrowings were outstanding under the letters of credit as of June 30, 2012 and 2011.

9. Derivative Instruments

The System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. These swaps have historically been used to effectively convert interest rates on variable rate bonds to fixed rates and rates on fixed rate bonds to variable rates. At June 30, 2012 and 2011, the notional values of outstanding interest rate swaps were $2,189,232 and $2,310,187, respectively.

The System recognizes the fair value of its interest rate swaps in the Consolidated Balance Sheets as assets, recorded in other noncurrent assets, or liabilities, recorded in other noncurrent liabilities, as appropriate. At June 30, 2012 and 2011, the fair value of interest rate swaps in an asset position was $94,082 and $64,426, respectively, while the fair value of interest rate swaps in a liability position was $248,511 and $141,287, respectively.

Prior to July 1, 2006, the System designated certain of its interest rate swaps as cash flow hedges, for accounting purposes, and accordingly deferred gains or losses associated with those swaps in net assets. As of June 30, 2012, the deferred net gain associated with these interest rate swaps was $4,660. The portion of this gain that will be reclassified into nonoperating gains (losses) over the next 12 months is immaterial.

9. Derivative Instruments (continued)

Beginning July 1, 2006, previously designated cash flow hedging relationships were de-designated for accounting purposes. Accordingly, all changes in the fair value of interest rate swaps have been recognized in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets. A net nonoperating loss of $77,568 was recognized for the year ended June 30, 2012, while a net nonoperating gain of $25,257 was recognized for the year ended June 30, 2011.

The System's interest rate swap agreements include collateral requirements for each counterparty under such agreements, based upon specific contractual criteria. The System's collateral requirements are based upon Ascension Health Alliance's Senior Credit Group long-term debt credit ratings (Senior Debt Credit Ratings), as obtained from each of two major credit rating agencies, as well as the net liability position of total interest rate swap agreements outstanding with each counterparty. At June 30, 2012 and 2011, based upon the System's net liability positions and Senior Debt Credit Ratings, no collateral on interest rate swap agreements was required to be posted. The aggregate net fair value of interest rate swap agreements with credit-risk-related contingent features on June 30, 2012 and 2011, was a liability of $154,429 and $76,861, respectively.

10. Retirement Plans

Defined-Benefit Plans

Certain System entities participate in defined-benefit pension plans (the System Plans), which are noncontributory, defined-benefit pension plans covering substantially all eligible employees of certain System entities. Benefits are based on each participant's years of service and compensation. Substantially all of the System Plans' assets are invested in a master trust (the Trust) consisting of cash and cash equivalents, equity, fixed income funds, and alternative investments. Contributions to the System Plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to participants.

10. Retirement Plans (continued)

During the year ended June 30, 2012, the System approved and communicated to employees a redesign of associate retirement benefits, which affects certain System Plans, as well as provides an enhanced comprehensive defined contribution plan. These changes will become effective January 1, 2013. This redesign resulted in the recognition of one-time curtailment gains of $415,834, of which $414,294 was recognized in total impairment, restructuring and nonrecurring gains for the year ended June 30, 2012, with the remaining amount recognized in nonoperating losses for the year ended June 30, 2012. This redesign also resulted in a one-time decrease to the projected benefit obligation as of December 31, 2011. The projected benefit obligation is included in pension and other postretirement liabilities in the Consolidated Balance Sheets.

The assets of the System Plans are available to pay the benefits of eligible employees and retirees of all participating entities. In the event entities participating in the System Plans are unable to fulfill their financial obligations under the System Plans, the other participating entities are obligated to do so.

(Dollars in Thousands)

10. Retirement Plans (continued)

The following table sets forth the combined benefit obligations and assets of the System Plans at June 30, 2012 and 2011, components of net periodic benefit costs for the years then ended, and a reconciliation of the amounts recognized in the accompanying consolidated financial statements:

	Year Ended June 30, 2012	2011
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 5,734,449**	$ 5,618,553
Service cost	**194,906**	208,253
Interest cost	**311,981**	304,365
Amendments	**(5,463)**	(476)
Assumption change	**873,252**	(154,944)
Actuarial loss (gain)	**1,051**	(29,136)
Acquisitions	**131,174**	–
Curtailment	**(561,854)**	–
Benefits paid	**(242,250)**	(212,166)
Projected benefit obligation at end of year	**6,437,246**	5,734,449
Accumulated benefit obligation at end of year	**6,341,693**	5,140,261
Change in plan assets:		
Fair value of plan assets at beginning of year	**5,397,593**	4,624,393
Actual return on plan assets	**711,555**	848,439
Employer contributions	**14,421**	136,927
Acquisitions	**111,358**	–
Benefits paid	**(242,250)**	(212,166)
Fair value of plan assets at end of year	**5,992,677**	5,397,593
Net amount recognized at end of year and funded status	**$ (444,569)**	$ (336,856)

The System Plans' funded status as a percentage of the projected benefit obligation at June 30, 2012 and 2011, was 93.1% and 94.1%, respectively. The System Plans' funded status as a percentage of the accumulated benefit obligation at June 30, 2012 and 2011, was 94.5% and 105.0%, respectively.

(Dollars in Thousands)

10. Retirement Plans (continued)

Included in unrestricted net assets at June 30, 2012 and 2011, are the following amounts that have not yet been recognized in net periodic pension cost for the System Plans:

	Year Ended June 30, 2012	2011
Unrecognized prior service credit	$ **(16,230)**	$ (69,548)
Unrecognized actuarial loss	**433,352**	33,874
	$ **417,122**	$ (35,674)

Changes in plan assets and benefit obligations recognized in unrestricted net assets for System Plans during 2012 and 2011, include:

	Year Ended June 30, 2012	2011
Current year actuarial loss (gain)	$ **48,601**	$ (671,223)
Amortization of actuarial loss (gain)	**350,877**	(130,321)
Current year prior service credit	**(5,463)**	(476)
Amortization of prior service credit	**58,781**	11,855
	$ **452,796**	$ (790,165)

	Year Ended June 30, 2012	2011
Components of net periodic benefit cost		
Service cost	$ **194,906**	$ 208,253
Interest cost	**311,981**	304,365
Expected return on plan assets	**(447,703)**	(361,295)
Amortization of prior service credit	**(10,646)**	(11,855)
Amortization of actuarial loss	**16,931**	130,321
Curtailment gain	**(415,834)**	–
Settlement gain	**(111)**	–
Net periodic benefit cost	$ **(350,476)**	$ 269,789

(Dollars in Thousands)

10. Retirement Plans (continued)

The prior service credit and actuarial loss included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending June 30, 2013, are approximately $6,500 and $63,900, respectively.

The assumptions used to determine the benefit obligation and net periodic benefit cost for the System Plans are set forth below:

	June 30,	
	2012	**2011**
Weighted-average discount rate	**4.42%**	5.63%
Weighted-average rate of compensation increase	**4.00%**	4.00%
Weighted-average expected long-term rate of return on plan assets	**8.43%**	8.50%

The System Plans' assets are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. Diversification is achieved by allocating to funds and managers that correlate to one of three economic strategies: growth, deflation and inflation. Growth strategies include U.S. equity, emerging market equity, global equity, international equity, directional hedge funds, private equity, high yield and private credit. Deflation strategies include core fixed income, absolute return hedge funds and cash. Inflation strategies include inflation-linked bonds, commodity-related investments, and real assets. The System Plans use multiple investment managers with complementary styles, philosophies, and approaches. In accordance with the System Plans' objectives, derivatives may also be used to gain market exposure in an efficient and timely manner.

In accordance with the System Plans' asset diversification targets, as presented in the table that follows, the Trust holds certain alternative investments, consisting of various hedge funds, real asset funds, private equity funds, commodity funds, private credit funds and certain other private funds. These investments do not have observable market values. As such, each of these investments is valued at net asset value as determined by each fund's investment manager, which approximates fair value. The fair value of the System Plans' alternative investments as of June 30, 2012, is reported in the fair value measurement table that follows. Collectively, these

(Dollars in Thousands)

10. Retirement Plans (continued)

funds have liquidity terms ranging from weekly to annual with notice periods ranging from 1 to 93 days. Due to redemption restrictions, investments of certain private funds, whose fair value was approximately $515,000 at June 30, 2012, cannot be redeemed. However, the potential for the System Plans to sell their interest in real asset funds and private equity funds in a secondary market prior to the end of the fund term does exist.

The investments in these alternative investment funds may also include contractual commitments to provide capital contributions during the investment period, which is typically five years, and may extend to the end of the fund term. During these contractual periods, investment managers may require the System Plans to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2012, investment periods expire between July 2012 and March 2018. The remaining unfunded capital commitments of the Trust total approximately $528,000 for 50 individual contracts as of June 30, 2012.

The weighted-average asset allocation for the System Plans at the end of fiscal 2012 and 2011 and the target allocation for fiscal 2013, by asset category, are as follows:

	Target Allocation	Percentage of Plan Assets at Year-End	
Asset Category	2013	2012	2011
Growth	50%	**49%**	52%
Deflation	30	**32**	32
Inflation	20	**19**	16
Total	100%	**100%**	100%

(Dollars in Thousands)

10. Retirement Plans (continued)

The following tables summarize fair value measurements at June 30, 2012 and 2011, by asset class and by level, for the System Plans' assets and liabilities. As also discussed in the Fair Value Measurements note, the System follows the three-level fair value hierarchy to categorize plan assets and liabilities recognized at fair value, which prioritizes the inputs used to measure such fair values. The inputs and valuation techniques discussed in the Fair Value Measurements note also apply to the System Plans' assets and liabilities as presented in the following tables.

	Level 1	Level 2	Level 3	Total
June 30, 2012				
Short-term investments	$ 192,025	$ 5,392	$ –	$ 197,417
Derivative assets – interest rate	53,054	92,049	757	145,860
Derivative assets – other	10,937	653	13,472	25,062
U.S. government obligations	–	2,189,580	1,903	2,191,483
Corporate and foreign fixed income securities	70,238	387,734	28,308	486,280
Asset-backed securities	–	194,201	14,243	208,444
Equity securities	782,558	–	23,200	805,758
Alternative investments	–	–	1,993,923	1,993,923
Assets not at fair value				874,681
Total				6,928,908
Derivative liabilities – interest rate	1,990	51,180	33	53,203
Derivative liabilities – other	3,859	134	6,022	10,015
Investments sold, not yet purchased	–	29,342	–	29,342
Liabilities not at fair value				843,671
Total				936,231
Fair value of plan assets				$ 5,992,677

(Dollars in Thousands)

10. Retirement Plans (continued)

	Level 1	Level 2	Level 3	Total
June 30, 2011				
Short-term investments	$ 433,526	$ 12,682	$ –	$ 446,208
Derivative assets – interest rate	717	3	65,727	66,447
Derivative assets – other	74	2,939	1,159	4,172
U.S. government obligations	–	1,734,828	2,129	1,736,957
Corporate and foreign fixed income securities	–	406,793	19,462	426,255
Asset-backed securities	–	265,277	4,427	269,704
Equity securities	1,186,520	–	1,701	1,188,221
Alternative investments	–	–	1,591,483	1,591,483
Assets not at fair value				221,405
Total				5,950,852
Derivative liabilities – interest rate	17	283	258,882	259,182
Derivative liabilities – other	307	1,067	16,371	17,745
Investments sold, not yet purchased	–	56,451	–	56,451
Liabilities not at fair value				219,881
Total				553,259
Fair value of plan assets				$ 5,397,593

(Dollars in Thousands)

10. Retirement Plans (continued)

For the years ended June 30, 2012 and 2011, the changes in the fair value of the System Plans' assets measured using significant unobservable inputs (Level 3) consisted of the following:

	Net Derivatives	U.S. Government Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Alternative Investments
June 30, 2012						
Beginning balance	$ (208,367)	$ 2,129	$ 19,462	$ 4,427	$ 1,701	$ 1,591,483
Total actual return on plan assets	167,900	48	1,431	(211)	(196)	(14,183)
Purchases, issuances, and settlements	48,641	(274)	9,662	10,517	21,690	416,623
Transfers (out of) into Level 3	–	–	(2,247)	(490)	5	–
Ending balance	$ 8,174	$ 1,903	$ 28,308	$ 14,243	$ 23,200	$ 1,993,923
Actual return on plan assets relating to plan assets still held at June 30, 2012	$ 9,095	$ 11	$ (820)	$ (477)	$ –	$ (49,802)

	Net Derivatives	U.S. Government Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Alternative Investments
June 30, 2011						
Beginning balance	$ (258,049)	$ 2,241	$ 52,193	$ 4,790	$ 122,447	$ 1,163,027
Total actual return on plan assets	57,843	99	1,976	(8)	33,096	171,459
Purchases, issuances, and settlements	(8,161)	(211)	(29,882)	376	(153,343)	256,997
Transfers out of Level 3	–	–	(4,825)	(731)	(499)	–
Ending balance	$ (208,367)	$ 2,129	$ 19,462	$ 4,427	$ 1,701	$ 1,591,483
Actual return on plan assets relating to plan assets still held at June 30, 2011	$ (25,056)	$ 65	$ (195)	$ 195	$ –	$ 154,299

The Trust has entered into a series of interest rate swap agreements with a net notional amount of $948,150. The combined targeted duration of these swaps and the Trust's fixed income investments approximates the duration of the liabilities of the Trust. Currently, 60% of the dollar duration of the liability is subject to this economic hedge. The purpose of this strategy is to economically hedge the change in the net funded status for a significant portion of the liability that can occur due to changes in interest rates.

(Dollars in Thousands)

10. Retirement Plans (continued)

The expected long-term rate of return on the System Plans' assets is based on historical and projected rates of return for current and planned asset categories in the investment portfolio. Assumed projected rates of return for each asset category were selected after analyzing historical experience and future expectations of the returns and volatility for assets of that category using benchmark rates. Based on the target asset allocation among the asset categories, the overall expected rate of return for the portfolio was developed and adjusted for historical and expected experience of active portfolio management results compared to benchmark returns and for the effect of expenses paid from plan assets.

Information about the expected cash flows for the System Plans follows:

Expected employer contributions 2013	$ 32,500
Expected benefit payments:	
2013	371,100
2014	364,200
2015	371,800
2016	384,900
2017	396,900
2018–2022	2,065,000

The contribution amount above includes amounts paid to the Trust. The benefit payment amounts above reflect the total benefits expected to be paid from the Trust.

Other Postretirement Benefit Plans

In addition to the retirement plan described above, certain Health Ministries sponsor postretirement benefit plans that provide healthcare benefits to qualified retirees who meet certain eligibility requirements. The total benefit obligation of these plans at June 30, 2012 and 2011, is $47,428 and $44,446, respectively. The net obligation included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2012 and 2011, is $12,423 and $10,086, respectively. The change in the plans' assets and benefit obligations recognized in unrestricted net assets during the year ended June 30, 2012, was $6,551.

10. Retirement Plans (continued)

Defined-Contribution Plans

System entities participate in contributory and noncontributory defined-contribution plans covering all eligible associates. There are three primary types of contributions to these plans: employer automatic contributions, employee contributions, and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant's salary and, for certain entities, increases over specified periods of employee service. These benefits are funded annually and participants become fully vested over a period of time. Benefits for employer matching contributions are determined as a percentage of an eligible participant's contributions each payroll period. These benefits are funded each payroll period and participants become fully vested in these employer contributions immediately. Expenses for the defined-contribution plans were $128,250 and $113,337 during 2012 and 2011, respectively.

11. Self-Insurance Programs

Certain System hospitals and other entities participate in pooled risk programs to insure professional and general liability risks and workers' compensation risks to the extent of certain self-insured limits. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Trust funds and two captive insurance companies, Ascension Health Insurance, Ltd. (AHIL) and Edessa Insurance Company, Ltd. (Edessa) are established for the self-insurance programs. Edessa was acquired as part of the Alexian Brothers business combination, as discussed in the Organizational Changes note. Actuarially determined amounts, discounted at 6% for the System, excluding Alexian Brothers which are discounted at 3%, are contributed to the trusts and the captive insurance companies to provide for the estimated cost of claims. The loss reserves recorded for estimated self-insured professional, general liability, and workers' compensation claims include estimates of the ultimate costs for both reported claims and claims incurred but not reported, which are discounted at 6% in 2012 and 2011 for the System, except for Alexian Brothers, which are not discounted. Those entities not participating in the self-insured programs are insured under separate policies.

11. Self-Insurance Programs (continued)

Professional and General Liability Programs

Professional and general liability coverage is provided on a claims-made basis through a wholly owned onshore trust and through AHIL and Edessa.

AHIL has a self-insured retention of $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $185,000. AHIL retains $5,000 per occurrence and $5,000 annual aggregate for professional liability. AHIL also retains a 20% quota share of the first $25,000 of umbrella excess. The remaining excess coverage is reinsured by commercial carriers.

Edessa has a self-insured retention of $1,000 per occurrence with no aggregate. Excess coverage is provided through Edessa with limits up to $110,000. Edessa retains $10,000 per occurrence and $20,000 annual aggregate for professional liability. The remaining excess coverage is reinsured by commercial carriers.

Self-insured entities in the states of Indiana and Wisconsin are provided professional liability coverage on an occurrence basis with limits in compliance with participation in the Patient Compensation Funds. The Patient Compensation Funds apply to claims in excess of the primary self-insured limit.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is professional and general liability expense of $71,687 and $69,073 for the years ended June 30, 2012 and 2011, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are professional and general liability loss reserves of approximately $596,381 and $522,489 at June 30, 2012 and 2011, respectively.

AHIL and Edessa also offer physician professional liability coverage through insurance or reinsurance arrangements to nonemployed physicians practicing at the System's various facilities, primarily in Michigan, Indiana and Illinois. Coverage is offered to physicians with limits ranging from $100 per claim to $1,000 per claim with various aggregate limits.

(Dollars in Thousands)

11. Self-Insurance Programs (continued)

Workers' Compensation

Workers' compensation coverage is provided on an occurrence basis through a grantor trust. The self-insured trust provides coverage up to $1,000 per occurrence with no aggregate. The trust provides a mechanism for funding the workers' compensation obligations of its members. Workers' compensation coverage for Alexian Brothers is self-insured up to $400 per occurrence with no aggregate. Excess insurance against catastrophic loss is obtained through commercial insurers. Premium payments made to the trust are expensed and represent claims reported and claims incurred but not reported.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is workers' compensation expense of $40,256 and $41,973 for the years ended June 30, 2012 and 2011, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are workers' compensation loss reserves of $110,657 and $98,867 at June 30, 2012 and 2011, respectively.

12. Lease Commitments

Future minimum payments under noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:	
2013	$ 208,072
2014	191,994
2015	152,166
2016	117,939
2017	96,213
Thereafter	250,031
Total	$ 1,016,415

Certain System entities are lessees under operating lease agreements for the use of space in buildings owned by third parties, including medical office buildings (MOBs), and medical and information technology equipment. In addition, certain System entities have subleased space within buildings where the entity has a current operating lease commitment. Certain System entities are also lessors under operating lease agreements, primarily ground leases related to third-party-owned MOBs on land owned by the System entity.

(Dollars in Thousands)

12. Lease Commitments (continued)

The System's future minimum noncancelable payments associated with operating leases where a System entity is the lessee, as well as future minimum noncancelable receipts associated with operating leases where a System entity is the sublessor or lessor, are presented in the table that follows. Future minimum payments and receipts relate to noncancelable leases with terms of one year or more.

	Future Payments Where the System is Lessee	Future Receipts Where the System is Sublessor/ Lessor	Net Future Payments (Receipts)
Year ending June 30:			
2013	$ 208,072	$ 32,929	$ 175,143
2014	191,994	27,783	164,211
2015	152,166	21,691	130,475
2016	117,939	17,004	100,935
2017	96,213	13,398	82,815
Thereafter	250,031	275,190	(25,159)
Total	$ 1,016,415	$ 387,995	$ 628,420

Rental expense under operating leases amounted to $341,918 and $290,692 in 2012 and 2011, respectively.

13. Contingencies and Commitments

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. Regulatory investigations also occur from time to time. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the System's Consolidated Balance Sheet.

13. Contingencies and Commitments (continued)

In September 2010, Ascension Health received a letter from the U.S. Department of Justice (the DOJ) in connection with its nationwide review to determine whether, in certain cases, implantable cardioverter defibrillators were provided to certain Medicare beneficiaries in accordance with national coverage criteria. In connection with this nationwide review, identified System hospitals are reviewing applicable medical records and responding to the DOJ. The DOJ's investigation spans a time frame beginning in 2003 and extending through the present time. Through September 12, 2012, the DOJ has not asserted any claims against any System hospitals. The System continues to fully cooperate with the DOJ in its investigation.

The System enters into agreements with nonemployed physicians that include minimum revenue guarantees. The terms of the guarantees vary. The carrying amounts of the liability for the System's obligation under these guarantees were $26,675 and $15,395 at June 30, 2012 and 2011, respectively, and are included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheets. The maximum amount of future payments that the System could be required to make under these guarantees is approximately $26,300 and is included in the table that follows.

The System entered into agreements with sponsors for support through January 2017. The System's obligation under these agreements totals $65,808 at June 30, 2012, and is included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheets.

Guarantees and other commitments represent contingent commitments issued by Ascension Health Alliance Senior and Subordinate Credit Groups, generally to guarantee the performance of an affiliate to a third party in borrowing arrangements such as commercial paper issuances, bond financing, and other transactions. The terms of guarantees are equal to the terms of the related debt, which can be as long as 28 years.

(Dollars in Thousands)

13. Contingencies and Commitments (continued)

The following summary represents the maximum potential amount of future payments the Senior and Subordinate Credit Groups could be required to make under its guarantees and other commitments at June 30, 2012:

Hospital de la Concepción 2000 Series A debt guarantee	$	31,075
St. Vincent de Paul Series 2000A debt guarantee		28,300
Rehab Hospital of Indiana, Inc. guarantee		8,210
Advantage Health Solution		5,272
Mercy Care Plan guarantee		5,000
Physician revenue guarantees		26,300
Information technology commitments		39,622
Other		27,054
Total guarantees and other commitments	$	170,833

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Ascension Health Alliance

Our audits were conducted for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole. The Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs, the Credit Group Consolidated Balance Sheets, the Credit Group Consolidated Statements of Operations and Changes in Net Assets, and the Schedule of Credit Group Cash and Investments are presented for purposes of additional analysis and are not a required part of the basic consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the basic consolidated financial statements as a whole.

Ernst & Young LLP

September 12, 2012

Ascension Health Alliance

Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs

(Dollars in Thousands)

Years Ended June 30, 2012 and 2011

The net cost, excluding the provision for bad debt expense, of providing care to persons living in poverty and community benefit programs is as follows:

	June 30, 2012	2011
Traditional charity care provided	**$ 468,970**	$ 408,894
Unpaid cost of public programs for persons living in poverty	**406,057**	374,083
Other programs for persons living in poverty and other vulnerable persons	**75,724**	71,267
Community benefit programs	**335,436**	372,644
Care of persons living in poverty and community benefit programs	**$ 1,286,187**	$ 1,226,888

Ascension Health Alliance

Credit Group[1] Financial Statements
Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2012	2011
Assets		
Current assets:		
Cash and cash equivalents	$ **278,692**	$ 1,107,846
Short-term investments	**216,914**	237,461
Accounts receivable, less allowances for uncollectible accounts ($1,102,806 and $1,079,706 at June 30, 2012 and 2011, respectively)	**1,842,575**	1,687,189
Inventories	**207,048**	190,514
Due from brokers	**789,271**	–
Estimated third-party payor settlements	**158,513**	89,747
Other	**746,147**	438,063
Total current assets	**4,239,160**	3,750,820
Long-term investments	**10,356,808**	8,117,951
Property and equipment, net	**5,953,207**	5,987,804
Other assets:		
Investment in unconsolidated entities	**448,612**	389,167
Capitalized software costs, net	**635,871**	486,842
Due from Alexian Brothers Health System	**324,362**	–
Other	**675,802**	720,565
Total other assets	**2,084,647**	1,596,574
Total assets	$ **22,633,822**	$ 19,453,149

Continued on next page.

[1] The Credit Group Financial Statements are comprised of the System (see Note 1) excluding the System's investment in Via Christi Health, Inc. and assets liabilities and net assets of Alexian Brothers Health System. The Credit Group Financial Statements also include the System's noncontrolling interest (see Note 2) of the CHIMCO Alpha Fund, LLC (Alpha Fund) (see Notes 4 and 5), which represents $589,493, or approximately 6.3%, of the Alpha Fund's net assets. See Note 5 for further discussion of noncontrolling interests of the Alpha Fund.

	June 30, 2012	2011
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **38,276**	$ 29,563
Long-term debt subject to short-term remarketing arrangements	**1,094,425**	1,662,950
Accounts payable and accrued liabilities	**1,876,862**	1,814,600
Estimated third-party payor settlements	**371,831**	276,810
Due to brokers	**880,613**	–
Current portion of self-insurance liabilities	**206,057**	191,551
Other	**429,611**	103,093
Total current liabilities	**4,897,675**	4,078,567
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**3,488,091**	2,546,785
Self-insurance liabilities	**490,117**	448,624
Pension and other postretirement liabilities	**470,858**	396,058
Other	**1,236,189**[2]	676,648
Total noncurrent liabilities	**5,685,255**	4,068,115
Total liabilities	**10,582,930**	8,146,682
Net assets:		
Unrestricted		
Controlling interest	**10,979,371**	10,832,721
Noncontrolling interests	**647,515**[3]	42,739
Unrestricted net assets	**11,626,886**	10,875,460
Temporarily restricted	**322,365**	331,563
Permanently restricted	**101,641**	99,444
Total net assets	**12,050,892**	11,306,467
Total liabilities and net assets	$ **22,633,822**	$ 19,453,149

[2] Includes $238,142 representing the amount due to ABHS from Ascension Health Alliance attributable to ABHS's interest in investments held by Ascension Health Alliance.

[3] Includes $589,493 attributable to the Alpha Fund (see Notes 4 and 5).

Ascension Health Alliance

Credit Group[1] Financial Statements
Consolidated Statements of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended June 30, 2012	2011
Operating revenue:		
Net patient service revenue	**$ 15,113,938**	$ 14,565,006
Other revenue	**971,911**	789,975
Total operating revenue	**16,085,849**	15,354,981
Operating expenses:		
Salaries and wages	**6,461,456**	6,188,630
Employee benefits	**1,403,062**	1,444,867
Purchased services	**754,188**	771,836
Professional fees	**1,014,882**	889,375
Supplies	**2,235,902**	2,261,568
Insurance	**89,987**	92,168
Bad debts	**983,648**	991,974
Interest	**128,010**	129,014
Depreciation and amortization	**651,473**	656,859
Other	**1,774,154**	1,556,110
Total operating expenses before impairment, restructuring, and nonrecurring gains, net	**15,496,762**	14,982,401
Income from operations before self-insurance trust fund investment return and impairment, restructuring, and nonrecurring gains (losses), net	**589,087**	372,580
Self-insurance trust fund investment return	**17,197**	90,402
Impairment, restructuring, and nonrecurring gains (losses)	**301,153**	(92,387)
Income from operations	**907,437**	370,595
Nonoperating gains (losses):		
Investment return	**(137,550)**	1,129,859
Loss on extinguishment of debt	**(2,828)**	(1,007)
(Loss) gain on interest rate swaps	**(74,773)**	30,879
Income from unconsolidated entities	**8,830**	11,915
Contributions from business combinations	**6,655**	–
Other	**(69,475)**	(68,999)
Total nonoperating (losses) gains, net	**(269,141)**	1,102,647
Excess of revenues and gains over expenses and losses	**638,296**	1,473,242
Less noncontrolling interests	**16,119**	27,484
Excess of revenues and gains over expenses and losses attributable to controlling interest	**622,177**	1,445,758

Continued on next page.

[1] Includes the loss of $136,778 attributable to the Alpha Fund. Of the Alpha Fund's loss, a loss of $9,278 is included in the noncontrolling interests.

	Year Ended June 30, 2012	2011
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	**$ 622,177**	$ 1,445,758
Transfer to sponsors and other affiliates, net	**(44,947)**	(14,495)
Contributed net assets	**(400)**	(374)
Net assets released from restrictions for property acquisitions	**68,741**	70,555
Pension and other postretirement liability adjustments	**(447,982)**	793,897
Change in unconsolidated entities' net assets	**(4,991)**	5,592
Other	**9,050**	(2,778)
Increase in unrestricted net assets, controlling interest, before (loss) gain from discontinued operations and cumulative effect of change in accounting principle	**201,648**	2,298,155
(Loss) gain from discontinued operations	**(54,998)**	19,421
Cumulative effect of change in accounting principle	**–**	(45,993)
Increase in unrestricted net assets, controlling interest	**146,650**	2,271,583
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	**16,119**	27,484
Distributions of capital	**(578,445)**	(33,854)
Contributions of capital	**1,167,102**	7,973
Increase in unrestricted net assets, noncontrolling interests	**604,776**[2]	1,603
Temporarily restricted net assets, controlling interest:		
Contributions and grants	**100,667**	100,679
Net change in unrealized gains/losses on investments	**(5,333)**	15,714
Investment return	**4,695**	8,295
Net assets released from restrictions	**(102,713)**	(103,654)
Other	**(6,514)**	496
(Decrease) increase in temporarily restricted net assets, controlling interest	**(9,198)**	21,530
Permanently restricted net assets, controlling interest:		
Contributions	**5,081**	8,030
Net change in unrealized gains/losses on investments	**(25)**	1,692
Investment return	**(217)**	(62)
Other	**(2,642)**	(87)
Increase in permanently restricted net assets, controlling interest	**2,197**	9,573
Increase in net assets	**744,425**	2,304,289
Net assets, beginning of year	**11,306,467**	9,002,178
Net assets, end of year	**$ 12,050,892**	$ 11,306,467

[2] Includes net contributions of $598,771, comprised of distributions of $548,962 and contributions of $1,147,733, attributable to the Alpha Fund.

Ascension Health Alliance

Schedule of Credit Group Cash and Investments
(Dollars in Thousands)

June 30, 2012

The Credit Group's cash and investments at June 30, 2012, are presented in the table that follows. Total cash and investments, net, includes both the Credit Group's membership interest in the Alpha Fund as well as the noncontrolling interests held by other Alpha Fund members. Credit Group unrestricted cash and investments, net, represent the Credit Group's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30, 2012
Cash and cash equivalents	$ 278,692
Short-term investments	216,914
Long-term investments	10,356,808
Subtotal	10,852,414
Other Alpha Fund and Ascension Legacy Portfolio assets and liabilities:	
In other current assets	360,999
In other long-term assets	2,924
In accounts payable and accrued liabilities	(12,779)
In other current liabilities	(322,873)
In other noncurrent liabilities	(157,073)
Due from (to) brokers, net	(91,342)
Total cash and investments, net	10,632,270
Less noncontrolling interests of Alpha Fund	589,493
Less Alexian Brothers Health System Interest in investments held by Ascension Health Alliance	238,124
Credit Group cash and investments, including assets limited as to use	9,804,653
Less assets limited as to use	1,064,385
Credit Group unrestricted cash and investments, net	$ 8,740,268

At June 30, 2011, the Credit Group's investments were comprised of its pro rata share of the Ascension Legacy Portfolio's funds held for participants and certain other investments.

	June 30, 2011
Cash and cash equivalents	$ 1,107,846
Short-term investments	237,461
Long-term investments	8,117,951
Credit Group cash and investments	9,463,258
Less assets limited as to use	994,297
Credit Group unrestricted cash and investments	$ 8,468,961

Tab 16

Attachment C
Contribution to the Orderly Development of Health Care – 2

Letters of Support

Letters to be submitted separately

Tab 17

Attachment C
Contribution to the Orderly Development of Health Care – 5

Performance Improvement Plan

Saint Thomas Health
Quality and Patient Safety Improvement Plan
Fiscal Year 2013
(July 1, 2012 – June 30, 2013)

I. Introduction

The hospitals of Saint Thomas Health (STHe) are committed to the continuous improvement of the quality, reliability and safety of the care they provide. This plan serves as the supporting document for the organizational structures and functions that are the vehicles of safe, reliable, high-quality patient care.

The STHe governing board has the ultimate responsibility for the quality and safety of care provided throughout the system. Any changes or revisions to this plan are presented for approval to the STHe Clinical Quality Committee of the Board of Trustees annually and on an as-needed basis. Additional approval of this plan is required annually by the STHe Board of Directors.

All data used within the STHe quality and patient safety program is legally protected from discovery by TCA 63-6-219 and the Ascension Health Patient Safety Organization (PSO) as Patient Safety Work Product (PSWP).

II. About the Plan

This plan is based on the concepts of continuous improvement, collaboration and a cultural approach to patient safety and quality that strives to achieve the following:

- Creation of a just culture that is safe for patients, associates, physicians, volunteers and visitors and minimizes risk to system assets.
- Promotion of respect, sensitivity and caring in regard to our patients' individual needs and expectations.
- Efficient, effective, timely and safe use of available resources.
- Responsible decision-making and priority-setting through interdisciplinary collaboration and by utilization of available data.
- Process and outcome monitoring that reliably measures the quality and safety of patient care.
- Comparative evaluation of organizational and system measurements against established benchmarks and industry norms.
- Ongoing integration of established best practices into our delivery of patient care.
- Internal and external recognition of our commitment to safe, reliable, high quality care.
- Utilization of common methodologies in the design, testing, implementation and evaluation of improvements.

- The goals set forth by Ascension Health's High Reliability Organization – Healing without Harm by 2014.

The goals set forth by Ascension Health's participation in CMS's Healthcare Engagement Network as part of the Partnership for Patients.

For the purposes of prioritization of needs and evaluation of effectiveness in FY 11, the following factors have been identified in consideration of the quality and patient safety program:

Key Innovations

- Successful early-adoption of Ascension Health's High Reliability Organization for Healing without Harm by 2014 with observed 80% reduction in serious safety events across the STHe since 2008
- Development of an Innovation Unit at Saint Thomas Hospital
- Baptist Hospital's participation in Ascension Health's Employee Safety Program pilot and its participation in OSHA's Voluntary Protection Program certification.

Strengths and Accomplishments

- Senior leadership engagement in quality and safety, most notably the SafeCare program
- Medical staff championship of quality initiatives and the SafeCare program
- Associate-level engagement with the SafeCare program and the safety event reporting structure including the implementation of unit-based associate "safety coaches"
- Strong quality and safety departmental leadership at each facility
- "Priority for Action" success within the Ascension Health System
- Proactive facility and medical staff leadership throughout the quality and patient safety committee structures
- Multiple awards, certifications and recognition achieved by the hospitals of STHe during FY 12.
  Successful Process Improvement (PI) activities as each hospital; typically using LEAN methodologies.
  Participation in Tennessee Initiative for Perinatal Quality (TIPQC) by both Baptist Hospital and Middle Tennessee Medical Center
  Baptist and MTMC's continued participation in the Tn Quality Award with both facilities achieving Level 2 certification in 2012.

Weaknesses

- Integration of process improvement and leadership expectations into daily work functions at the associate level
- Engagement of mid-level leadership and front-line staff in performance improvement due to real or perceived resource limitations and competing priorities
- Active cross-functional performance improvement teams driving PI and best

practices across the system using LEAN methodologies

- Orientation to performance improvement for new leaders and associates
- Consistency in core measures performance
- Efficient and effective communication methods to provide timely feedback to front-line staff and physicians relating to quality and safety performance
- Integration of electronic and manual data management processes
- Quality Information Center resources and our constrained ability to respond to internal and external requests for data

Failure to leverage our Cerner investment in order to drive clinical quality interventions via the EHR
Lack of a quality reporting standard for all the hospitals in the system
Lack of physician oversight and participation in collection and use of clinical quality data
Lack of physician support for meeting national quality metrics unless there is compelling evidence of improved quality outcomes in association with interventions mandated by those metrics.

Opportunities

- Utilization of LEAN improvement methods to eliminate waste and add value to processes
- Leveraging of the relationship between quality and information technology to advance our ability to interface with clinical databases, maximize electronic resources and develop strategies for real-time abstraction of concurrent data
- Identification of common data sets and coalescence of data definitions with clinical workflow and extraction methods
- Integration of the Behavioral Accountability Tool into the hiring process
- Joining and submission of data and information to the Ascension Health Patient Safety Organization
  Increased use of Cerner and our EHR platforms to prompt and drive clinical quality initiatives and interventions.
  Further reduction in patient harm by participation in Ascension Health's Healthcare Engagement Network
  Futher partnership with the Tennessee Hospital Association's Center for Patient Safety to drive quality and patient safety behaviors and programs.

Threats

- Unfunded mandates and multiple external reporting priorities that require utilization of existing resources and the limitations those mandates create in our ability to focus on internal quality needs and opportunities
- The Blue Cross/Blue Shield Pay for Performance Plan
- Uncertainty regarding CMS and AHRQ public reporting of quality and safety indicators
- Recovery audit contractors as related to quality outcomes and physician performance
- Capital budget restraints from Ascension Health
- CMS Value Base Purchasing which became effective July 1, 2011 and

represents significant potential for loss of reimbursement if Core measure or HCAHPS performance does not improve.
Significant financial penalties for failure to meet CMS readmission standards

III. Approach to Performance Improvement

Principles and Key Terms

- Patient Focus – High reliability organizations and those with established quality reputations focus on exceeding patient expectations.
- Recovery-oriented – Services are characterized by a commitment to holistic, reverent care that promotes flexibility, choice and patient-defined treatment goals.
- Employee empowerment – Effective programs involve associates at all levels of the organization for the purpose of improving quality and increasing subsidiarity.

- Leadership commitment – Strong and proactive leadership throughout the organization maintains focus on quality and safety goals that are consistent with the organization's mission and strategic plan.
- Prevention over Correction – High reliability organizations emphasize proactive process design that achieves front-end outcome enhancement rather than process redesign in response to safety events.

LEAN Process Improvement – robust system wide efforts using of the principles of the Toyota Management System from manufacturing

- Affiliate Physician Engagement – Physician involvement throughout quality and patient safety improvement processes greatly increases the potential success of those efforts.
- Chartering – To achieve effective outcomes in an efficient and timely manner, performance improvement initiatives are chartered. Chartering encourages and sustains:
    - Setting of priorities
    - Strategic alignment of initiatives with the Mission, Vision and Values
    - Focus on scope, timeline and organizational relevance
    - Collaboration with and coordination of improvement efforts across the system

IV. Strategic Goals and Priorities for Action

Strategic Goal #1 – High Reliability Organization and Healing without Harm by 2014

STHe is pursuing four initiatives to build a high-reliability, safety-focused culture as follows:

1. Recognition of safety as an organizational imperative
2. Integration of error-prevention behaviors into all daily work processes
3. Focused efforts to simplify work processes
4. Event analysis which involves key stakeholders and focuses on communication of lessons-learned and proactive safety precepts

To this end, STHe partnered with Healthcare Performance Improvement, LLC (HPI) four years ago to provide diagnostic assessments of each facility, tools and resources, leadership and physician training, and on-going consulting services to aid in the advancement of our culture of safety and achievement of high-reliability organization designation. This was pilot work done by STHe that was subsequently picked up by Ascension Health.

The functional result of our partnership with HPI is the SafeCare program, which was initiated at Saint Thomas Hospital in 2007. Since that time the program has been rebranded as Ascension Health's High Reliability Healthcare initiative. The implementation of this program has included:

- Diagnostic assessment using common cause analysis and interviews with leaders, physicians and staff
- Development of behavioral safety expectations and error prevention techniques
- Communication of those expectations to all physicians and staff through comprehensive SafeCare education
- Education of leaders in "Leadership Method", which includes walking rounds, safety huddles and the concept of '200% accountability' regarding patient safety

- Revision of human resource policies to support SafeCare behavioral expectations
- Designation and training of associate-level safety coaches to promote and support SafeCare in departments and units
- Classification of safety events and near-miss events using standard nomenclature
- 80% sustained reduction in actual serious safety events across STHe and sustained increased reporting of precursor and near-miss events.

The SafeCare program is the primary strategic quality initiative throughout STHe facilities and remains a top priority throughout STHe for FY 13.

Metrics related to the SafeCare program that will be reported at both the facility and system board levels include:

- Serious Safety Event Rate per 10,000 Adjusted Patient Days
- Number of Serious Safety Events, Precursor Safety Events and Near-Miss Events
- Hospital-Acquired Conditions

In addition, metrics related to the SafeCare program that will be reported at the facility leadership level include:

- Number of "Red Rule" Violations
- Average Number of Safety Coach Observations
- Number of "Déjà vu" Events
- Number of "Déjà vu" Events Resulting in Serious Safety Events

<u>Strategic Goal #2 – Priorities for Action</u>

Priorities for Action (PFA) are specific measures, defined by Ascension Health and reported at the facility, Saint Thomas Health and Ascension Health corporate levels. Priorities for Action for FY 13 include:

- Ventilator Associated Pneumonia in the ICU
- Rate of Central Line Sepsis in the ICU
- Facility-Acquired Pressure Ulcer Rate
- Rate of Falls with Serious Injury
- Rate of Birth Trauma
- Neonatal Mortality Resulting from a Serious Safety Event
- Overall Neonatal Mortality
- Risk-Adjusted Mortality
- Clean Surgical Site Infection Rate
- Glycemic Control in the ICU
- Other metrics as determined by Ascension Health could potentially be included prior to the end of FY 13 and the overlap with Ascenion's HEN project via CMS is still being delineated at this time.

Strategic Goal #3 – Core Measures

All STHe facilities collect and report Core Measures for both internal and external (public-reporting) purposes as follows:

- Pneumonia
- Heart Failure
- Acute Myocardial Infarction
- Surgical Care Improvement Project
- Hospital Outpatient Measures

Perinatal Safety
DVT
ED metrics
Hospital Acquired Conditions
Hospital acquired Infections

Core measures compliance remains a top priority for FY 13 and into the foreseeable future in part due to the financial penalites tied to Value Based Purchasing (VBP) initiatives of CMS.

At the facility level, core measures are reported at the leadership, Medical Executive Committee and board levels. Composite facility performance is also reported to the STHe Board of Trustees. (Attachment 2)

Incidences of non-compliance are identified at the patient level for investigation and follow-up and unit-level performance data is analyzed for patterns, trends and process improvement opportunities.

Every six months, physicians across STHe are evaluated to include their core measures results in addition to other key quality metrics as part of the FPPE/OPPE process.

Strategic Goal #4 – Exceptional Patient Experience

With direction from the Ascension Health Experience Team, the facilities of STHe strive to achieve the highest possible level of satisfaction as experienced by our patients, associates and physicians.

Patient satisfaction/experience and HCAHPS measurements are conducted regularly by Professional Research Consultants, Inc. to include a patient sampling of both inpatient and outpatient units with unit-level results available to hospital and medical staff leadership on a monthly basis.

As part of our commitment to the patient's experience of care within STHe facilities, the following strategies have been employed:

- Closed-loop feedback

- Patient rounding
- Support of associate engagement, empowerment and alignment
- Development of emotional and spiritual care

- Expectation of efficient workflow as evidenced by perceptions of improved coordination, communication and cooperation among all those involved in the patient's experience of care

Key metrics reported to the STHe Board of Trustees include:
- STHe Net Promoter Score
- Facility-Specific Net Promoter Scores

Key metrics reported at the facility-level to medical staff and hospital leadership groups include:
- Facility-Specific Net Promoter Score
- HCAHPS Rates by Category
- Unit-Specific Net Promoter Scores (both inpatient and outpatient)

For FY13, the Net Promoter Score goal for each facility is:
- Saint Thomas Hospital – 81
- Baptist Hospital – 71
- Middle Tennessee Medical Center - 61

The closing date for calculation of this measurement will be May 15, 2013.

Strategic Goal #5: Quality Awards, Recognition and Certifications

By January 1, 2013, each facility will evaluate its readiness for application for available awards, recognition and certification such as:
- Tennessee Quality Award
- Baldrige Award
- Nursing Magnet Status

Strategic Goal #6: Expansion and leveraging of Health Information Technology

Health information technology (HIT) and the electronic medical record (EMR) are foundational with respect to the delivery of high quality healthcare both at the patient and population level. The ability of STHe to deliver high quality and cost effective care, satisfy regulatory and payer mandates, and participate in emerging models of healthcare delivery will require the extension of our current electronic medical record implementation, the rational utilization of developing health information technologies and the leveraging of those technologies across the continuum of patient care and customer experience. Achievement of that goal will requires several areas of focused effort involving extension of electronic medical record implementation in the acute care and ambulatory areas, infrastructure upgrade and the as well as the integration of these platforms into a coherent architecture spanning the continuum of care. These efforts are outlined as specific goal components below.***STHe Meaningful Use Initiative***

Because EMR functionality can have a profound influence on healthcare quality

the federal government, via the American Recovery and Reinvestment Act (ARRA), has mandated that all healthcare providers will have implemented an EMR by federal FY16 or face financial penalty. In order to encourage the early implementation of EMRs, ARRA legislation establishes financial incentive for providers (hospitals and clinicians) who demonstrate the "meaningful use" of EMRs prior to end of federal FY 15. CMS has defined criteria by which healthcare providers shall demonstrate that they are "meaningful users" of an electronic medical record. These criteria were broadly outlined in 3 stages with increasing levels of implementation at each stage. Stage I criteria were defined in FY 11; the 90 day Stage I certification period was successfully achieved by Baptist Hospital, Middle Tennessee Medical Center and Saint Thomas Hospital in FY 12. The Stage I Meaningful Use criteria have been proposed by CMS and represent an expansion of both the scope of EMR functionality and the extent of clinical adoption of existing functionality; it is expect that CMS will finalize Stage II criteria in Q12012. In addition CMS has amended the Meaningful Use Stage II timeline; these timeline changes have created a second phase to Stage I which will consist of a 365 day reporting period employing the initial Stage I criteria, and a delay in Stage II requirements of 1 Federal Fiscal year. Accordingly STHe will target completion of Stage I (second phase) Meaningful Use certification over the period 10/1/12-9/30/13. Simultaneously throughout FY 13 STHe will be deploying the functionality and driving the increased clinical adoption rates that will be necessary to support Meaningful Use Stage II certification which will begin on 10/1/13.

Infrastructure Vitalization

Successful utilization of current health information technology, and implementation of the new EMR functionality necessary to achieve EMR Meaningful Use, are critically dependent upon a stable, well maintained technology infrastructure. That infrastructure must provide clinical workflow enhancing components specifically related to system access facilitation, flexible end-user hardware, and reliable wireless capability. Finally adequate resources must be deployed to deliver the level of real-time end-user support and system reliability required to deliver high quality care. Infrastructure delivery and maintenance as well end-user support are delivered across STHe by Ascension Health Information Technology (AHIS) and that service will be a mission critical component for this quality plan. To that end STHe has initiated a major infrastructure refresh across the clinical environment. This refresh has resulted in upgrade to core switches, edge closets and routers and fiber to clinical PC. In addition focused areas of the wireless network were refreshed. Those upgrades were completed in FY12 and the second phase of infrastructure refresh – the implementation of a virtualized desktop environment with enhanced access for clinical end-users is underway. This second phase of infrastructure refresh is target for completion during Q2 of FY13. The completion of the infrastructure refresh will transform the day-to-day end-user experience and support the continued transition of clinical workflow from

paper to digital processes.

STHe eHealth Strategy

The delivery of safe, highly reliable, clinically efficient, economically sustainable healthcare is dependent upon the availability of patient-centric clinical data from

across the continuum of care, presented in the context of a single integrated, longitudinal health record ; *One Patient – One Chart*. Significantly this comprehensive clinical record must be integrated into a platform supporting broad health information exchange across provider communities, sophisticated patient access to personal health data and tools for improved engagement, comprehensive consumer functionality supporting enhanced access and business growth, and robust business intelligence capability driving improved individual and population health via near-real time performance analytics and prospective population modeling. These components are being accounted for in the encompassing STHe eHealth Strategy. The STHe eHealth Strategy rests on 3 integrated components which leverage and augment the platform EMRs within our system:

1. Health Information Exchange (HIE)
    a. STHe Private HIE – STHe has been selected a the Ascension pilot site for the implementation of the db Motion Health Information Exchange Platform. In the initial phase this pilot project will create a "private" Health information exchange between the Cerner enterprise inpatient EMR and the STPS NextGen enterprise ambulatory EMR, providing an aggregated and semantically normalized composite view of a patients clinical data across the continuum of care. This view to consolidated clinical data is delivered at the point of care and within the workflows of the clinical end-users. Subsequent phases of this pilot are aimed at the inclusion of other ambulatory EMRs and data sources, with the ultimate goal of creating a robust health information exchange platform that will serve the Mission Point ACO. The first phase of the db Motion pilot is targeted for completion by 1/1/13
    b. Public HIE - Participation in Public health information exchange platforms at the regional, state and national levels will be important as STHe engages the traverses the emerging landscape of heathcare reform. Toward that end STHe has taken on leadership roles in both the regional HIE in the form of the Middle Tennessee eHealth Connect (MTeHC) project, and state-wide/national HIE in the form of the Health Information Partnership for Tennessee (HIPTN). The programs have tentative implementation dates in the first half of FY 13 and as these HIEs become functional and capable of data exchange STHe will participate via the dbMotion private exchange infrastructure.
2. Patient Portal
    a. Increasingly integrated health care delivery systems will distinguish themselves on the basis of the facility and seamlessness with which the interact with patients, and their ability to engage with customers (both current and prospective) in a pro-active and contextually aware fashion. The STHe Patient Portal, with sophisticated, integrated Customer Relationship Management capabilities, will allow STHe to more completely engage our patients in their own health

maintenance and expose a broad consumer base to timely, targeted resources and points of contact that will promote their interaction with our system. The Patient Portal and CRM suite are targeted for Q2 2012 delivery.

3. Busness Intelligence Platform
    a. Enterprise BI – STHe has been selected a the Ascension pilot site for the implementation of the Humedica Enterprise Analytics Platform. This platform aggregate semantically normalized clinical data and claims based administrative data sets, from the STHe Cerner acute care and STPS NextGen ambulatory care platforms, into a robust data warehouse. Both near real-time performance analytics, with granularity down to the individual provider level will allow ongoing evaluation of the effectiveness, efficiency and overall quality of our healthcare delivery. In addition the Humedica platform provides the capability to engage in prospective modeling of performance against specific population; that capability is critical as we enter into new healthcare models that incorporate increasingly shared risk. The first phase of the H pilot is targeted for completion by 1/1/13

V. Performance Improvement Structures

System Structure

The Quality/Patient Experience Council of STHe (Q/PE) is the oversight body of the core quality and patient safety committees and councils at each facility.

Key functions of this council include:

- Directing and tracking system level measures and results
- Sharing knowledge and lessons learned as a result of safety event monitoring at each facility
- Communication of relevant quality findings and trends
- Identification of policies and best practices for system-level implementation
- Fostering change while recognizing the individual quality and patient safety paradigms of each facility

Monitoring ongoing clinical research across STHe via St Thomas Research Institute which both monitors and serves as a coordinating body for such research.

The Medication Management Oversight Committee (MMOC) operates as a subcommittee of the Q/PE to analyze and address medication-process specific challenges as related to medication safety, medication ordering and administration and formulary development.

The goals and functions of this group include:

- Awareness and analysis of safety issues impacting bedside medication administration such as bar code technology, patient identification, smart

pump integration, nursing-pharmacy communications, etc.

- Recommendations for capital planning related to medication delivery systems and IT integration
- Work toward building a common STHe medication formulary to facilitate cost containment and efficiency
- Oversight of the Ascension Health medication safety Priority for Action efforts

The Saint Thomas Health (STHe) Clinical Foundation Suite (CFS) Governance Council (GC) is the primary group charged with setting the strategic goals, priorities and timelines for the implementation of the electronic health record. This multi-disciplinary group includes the CEO, CMO, CNO, IT Director as well as 5 physicians (including MEC members) from each campus.

This group is supported by the CIO, CMIO, Director of Pharmacy Informatics, Director of Nursing Informatics, Physician Network Executive and Corporate Compliance Officer. The STHe CFS GC meets every 6 weeks and provides multi-disciplinary input on HIT/EMR strategic direction, prioritization and budgeting recommendations relative to HIT initiatives, evaluation of HIT/EMR implementation progress, and oversight relative to HIT/EMR impact on clinical outcomes, quality and provider workflow. The STHe CFS GC interacts communicates with the STHe IT Shared Governance Council, the Quality / Patient Experience Council and the campus-specific MECs. It directs the STHe PIC relative to areas of focus regarding the technical aspects of HTI/EMR implementation. The majority of work for the STHe CFS GC in FY12 will focus on Meaningful Use qualification for BH, MTMC and STH and will consist of determination of the qualification period, evaluation of the implementation strategy and assessment of program resourcing.

The Information Management Council (IMC) is the group charged with translating the strategic direction set by STHe Senior Leadership into operationally appropriate projects at both the system and facility levels by managing project charters, setting Information Systems (IS) priorities, and directing Information Technology (IT) capital/OpEx spend in accordance with strategy. This group includes a multidisciplinary group chaired by the SVP of Operations, CMIO, CIO, VP Finance/Controller, STPS CMIO, Facility COO, Facility CNO, and ad hoc members deemed necessary.

Facility-Specific Structure and Interface with System Structure

Hospital structures supporting quality, patient safety and performance improvement report to the facility's Board of Trustees through its Medical Executive Committee and to the system level through the STHe Clinical Quality Committee of the Board of Trustees, the body responsible and accountable for all quality and patient safety functions throughout Saint Thomas Health.

The functional committees supporting quality and patient safety at each facility include:

- Infection Control Committee or equivalent group
- Pharmacy and Therapeutics Committee
- Medication Safety Committee or equivalent group
- Environment of Care Committee

Quality Council (Baptist Hospital and Saint Thomas Hospital) reports to the Medical Executive Committee of each facility and is comprised of executive, hospital and medical staff leadership. Quality Council is chaired by a physician and is the primary body for review of each hospital's Quality Scorecard, containing the key metrics listed in this plan.

Each facility's Quality Council:

- Promotes leadership participation in quality efforts
- Makes recommendations for quality and performance improvement efforts
- Addresses issues regarding Joint Commission accreditation and survey preparedness
- Identifies and oversees facility-specific improvement projects
- Tracks quality indicators and improvement projects
- Provides oversight of facility quality measures

Patient Safety Council (Baptist Hospital and Saint Thomas Hospital) reports error and event data to the Q/PE to affect positive change in each facility and throughout the system. Membership is comprised of senior executives, medical staff and clinical leadership under the direction of the Quality and Risk Management department. A physician chairman acts as facilitator of Patient Safety Council meetings.

Patient Safety Council functions to:

- Review safety events including serious safety events, precursor safety events and near misses as referred by the facility's Risk Manager
- Determine the occurrence of sentinel events and review resultant root cause analyses, making recommendations for additional corrective actions as indicated
- Ensure the completion of action plans completed in response to safety events
- Review Joint Commission's Sentinel Event Alerts and issue recommendations for addressing relevant concerns
- Review aggregate patient safety data, as provided by Ascension Health, for benchmarking purposes

- Assure the completion of "Culture of Safety" assessments and review findings
- Provide multidisciplinary oversight of all patient safety functions at the facility level

Quality/Patient Safety Council (Middle Tennessee Medical Center) integrates previously-defined functions and purposes of Quality Council and Patient Safety council into a single committee.

The Clinical Assessment Committee (at Baptist and Saint Thomas Hospitals) or Physician Excellence Committee (at Middle Tennessee Medical Center) performs multidisciplinary physician peer review at each facility, reporting to the Medical Executive Committee. The work of this committee is legally protected by TCA 63-6-219. These groups are chaired by a physician and supported by each facility's quality department.

The Clinical Assessment or Physician Excellence Committee:

- Adjudicates cases in which there are questions regarding standards of care
- Identifies ways to improve the quality and safety of patient care
- Analyzes how hospital and medical staff processes can be improved to eliminate the risk of recurrent error
- Ensures that physicians who are found not meeting the standard of care have access to resources, support and oversight to avoid subsequent events
- Tracks and analyzes physician practice patterns that indicate opportunity for improvement
- Recommends actions to the Medical Executive Committee

Provides peer coaching and counseling in response to individual physician performance variances

MEC Health Information Subcommittee: is one of the primary campus specific groups at each facility charged with technical assessment of HIT and EMR functionality and its impact on patient safety, clinical quality and provider workflow. The group consists of practicing physicians from a variety of subspecialties. The physician group is supported by administrative, pharmacy, clinical informatics and IT representatives. Each campus specific MEC HIT Subcommittee meets monthly and serves as a forum for physician input on HIT implementation and provides a direct mechanism for alignment of HIT initiatives with establish medical staff governance process. The campus specific MEC HIT Subcommittees meet collaboratively on a bi-monthly basis to address the impact of HIT implementation on the dissemination of best practices and evidence based therapies across the STHe network.

VI. Performance Improvement Models

LEAN Methodology

During FY 10, the facilities of Saint Thomas Health began integrating LEAN methodology into the performance improvement structure to assist in the development of solutions to more complicated organizational opportunities for improvement. STHe partnered with Healthcare Performance Partners, LLC to address specific concerns at each STHe hospital.

Additionally, leadership level positions have been approved and filled at each facility to assure the continuation of LEAN process improvements and facilitate LEAN events as new priorities are identified.

Plan-Do-Study-Act

The primary methodology for performance improvement efforts throughout the facilities of STHe is Plan-Do-Study-Act (PDSA), the model recognized by the Institute for Healthcare Improvement. PDSA relatively simple and process-oriented structure makes it ideal for unit-based and uncomplicated interdisciplinary performance improvement. Each component of this model is described as follows:

Plan

- Identification of potential opportunities for improvement
- Analysis and interpretation of data for problem discernment
- Determination of process and/or outcome measures
- Assignment of team members
- Proposal of solutions

Do

- Implementation of the proposed solution
- Collection of data based on defined process and/or outcome measures

Study

- Re-analysis of data
- Assessment of implementation results

Act

- Integration of changes into routine processes
- Involvement of other stakeholders, components or patients in the change
- Documentation and reporting of findings
- Completion of follow-up

VII. Performance Improvement Tools

The facilities of Saint Thomas Health use tools and instruments common to quality improvement processes and include:

- Flow-charting
- Brainstorming
- Nominal group technique
- Multi-voting
- Affinity diagrams
- Cause-and-Effect diagrams
- Histograms
- Pareto charts
- Run charts
- Control charts
- Benchmarking
- Root cause analysis
- Apparent cause analysis
- Common cause analysis

A description of each of these tools and the manner in which they may be used if found in Addendum C of this plan.

VIII. Annual Evaluation of Quality and Patient Safety Plan

A comprehensive review of quality and patient safety activities is conducted annually at the system and facility level through review of quality scorecards as well as other reports, findings and audits that have been collected throughout the past twelve months.

New priorities, initiatives, goals and expected outcomes are identified as previously described in this plan.

Each facility is responsible for evaluating its internal quality and patient safety program, including intersects with contracted services.

Tab 18

Attachment C
Contribution to the Orderly Development of Health Care – 5

Utilization Review Plan

Baptist Hospital
Nashville, Tennessee

Title: Utilization Review Plan	**Policy #:**
Developed By: Richard A. Orland, M.D. Medical Advisor Care Management Program	**Date: April 26**, 2013
Approved By:	**Date:**
Reviewed:	**Revised:**
Scope: Hospital – Wide	**Written:**

I. AUTHORITY (Title 42 Code of Federal Regulations 456.105)

Ultimate responsibility for the quality, appropriateness and clinical necessity of admissions, continued stays, and supportive services rests with the Saint Thomas Health (STHe) Board of Directors. The STHe Board of Directors authorizes the Baptist Hospital Medical Staff and Hospital Administration to demonstrate and promote effective and efficient patient care through the implementation of a Utilization Review (UR) plan.

II. RESPONSIBILITY

The Board of Directors, Chief Executive Officer of Baptist Hospital, and the Chief of the Medical Staff assigns and empowers the Utilization Review Committee (URC) to implement the Utilization Management Plan to support the hospital's mission and vision through collection and review of data that assures the appropriate allocation of hospital resources.

III. PURPOSE

The purpose of this UR plan is:

A. To assure effective and efficient utilization of available hospital facilities and services consistent with patient needs and professionally recognized standards of healthcare.
B. To identify opportunities for changes needed to maintain high quality and appropriate patient care, as well as identify over and under utilization of resources, quality related issues, and/or risk related issues.
C. To assure that documentation in the medical record substantiates the quality and utilization of services needed in the management and progress of every patient.

IV. ORGANIZATION (42 CFR 456.105, 106, 112 & 113)

A utilization review committee (URC) shall be established at Baptist Hospital to carry out the utilization review plan. It may be titled differently, i.e., "Clinical Resource Committee." The URC shall report all significant issues, findings and recommendations to the Medical Executive Committee at least annually, as evidenced in the Medical Executive Committee's minutes. It is the ultimate responsibility of the Board of Directors and Medical Staff to facilitate the efforts of the URC by providing assistance and direction in the process of implementing and/or maintaining

quality patient care.

A. Membership and Structure (A-0310 482.30, 217)

i. Either the Chief Medical Officer (CMO) or a physician committee member appointed by the CMO or Chief or Staff will serve as Chair of the URC. The Chair will make himself/herself available to facilitate and assist the Medical Advisor, Care Management, as need arises.

ii. Physician members who are part of the Baptist Hospital Medical Staff and who represent various medical staff departments shall be appointed by the CMO with assistance and input from the Chair and Medical Advisor. In addition to the Medical Advisor, a minimum of two practicing physicians shall serve on the URC. All Baptist Hospital Medical Staff physician members, including the Medical Advisor, will have voting privileges.

iii. Non-physician, non-voting members may include representatives from such areas as administration, care management, Clinical Integration, access/bed management, HIM, performance improvement, and Compliance. Other health care practitioners may be asked to serve as consultants to the committee and may be requested to attend meetings on an "as needed" basis.

iv. The Utilization Review Committee will meet as deemed necessary by the Chair, but at least four (4) times each calendar year. A quorum will be 33% of the URC physician membership.

v. The URC shall keep minutes of all meetings. The minutes shall summarize significant discussions, findings, and actions taken as a result of URC decisions or recommendations. Minutes, information, and data used by the URC will be maintained as peer review records including any findings or recommendations as required to assure confidentiality and compliance with all laws and regulations.

vi. The URC authorizes the Medical Affairs, Clinical Integration, Care Management, Finance, and HIM Departments to provide support services as needed for the performance of the URC.

vii. The URC recognizes the authority of the State QIO(s) in their role as to any assessment and monitoring of review activities.

viii. Per Tennessee Code Annotated (TCA) 63 – 6 – 219, data generated or utilized by the UR Committee will be maintained in confidence and secured to the fullest extent possible to protect from loss, defacement, tampering, or use by unauthorized persons. Information which identifies an individual or practitioner is considered privileged except for that information which is necessary to facilitate the review program by fiscal intermediaries and state agencies for payment of claims. Exceptions will be granted to other outside agencies only through signed, written agreements with the hospital or as required by law.

B. Condition of membership and conflict of interest (A-0310 482.30, section 3, 218)

i. All physician members of the committee shall serve renewable one-year memberships. Members are expected to attend at least 50% of scheduled meetings. The CMO, with the approval by the Chair of the URC, shall be responsible for appointing members to fill vacancies.

ii. No physician member shall have review responsibility for any case in which s/he had, has, or expects to have clinical involvement.

iii. No committee member shall have a direct financial interest, as defined by the Social Security Administration, in Baptist Hospital.

C. Responsibilities (A-0311 482.30)

i. To establish and carry out a review program in accordance with applicable state, federal and payer rules and requirements.

ii. To obtain, review and evaluate information generated by the hospital's Care Management program, Clinical Integration, and other departments. This may include information regarding:

a. Comparative data of physician specialties, services lines, DRGs, and individual physicians with respect to ALOS and charges/costs per case;
b. Denied days of care or denied costs of care received from third party payers specific to lack of precertification, medical necessity, or quality of care;
c. Average length of stay and Case Mix Index;
d. Numbers of cases that were sent to second-level physician review;
e. Case manager interventions related to days/costs saved
f. Avoidable days specific to obstacles that delay the progress of care or delivery of care and which may compromise the safety of patients and the quality of care
g. Other data and information pertaining to resource utilization and management as determined by the committee to be part of the agenda of each meeting.

Such information and measures will be reported to the URC during scheduled meetings.

iii. Along with Care Management Program staff, to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, and use of medical or hospital services, which may contribute to under- or over-utilization of services when indicated by the data.

iv. To review selected cases that with extended length of stay, extraordinarily high costs and/or excessive physician services as detected by Care Management Program staff as no longer meeting screening criteria for continued care at the inpatient level of care

v. To refer individual cases, where there is a concern regarding the quality of patient care, to the appropriate hospital or medical staff department.

vi. Participate in educational initiatives for physicians and other caregivers regarding the stewardship of healthcare resources.

vii. To adopt and modify review criteria and standards as needed and recommend changes in hospital procedures or medical staff practices that are identified by an analysis of review findings.

viii. To determine that point during any specific patient's hospitalization at which Medicare, Medicaid, and Title V Programs, and other third party payers should have no further financial

responsibility for the patient because of lack of medical need. The attending physician has the right to have the case reviewed by the URC and the QIO in the case of federally funded cases.

ix. To maintain liaison with the quality improvement and risk management functions in order to coordinate the findings of the program.

x. To provide utilization information, as requested, for credential review files.

xi. To review the Utilization Review plan annually and make recommendations regarding such to the CMO and URC Chair for revision.

V. METHODS AND TYPES OF REVIEW (42 CFR 456.121, 131)

Utilization review consists of a pre-admission and/or admission certification, appropriateness of continued stay and discharge readiness. These determinations, using standard criteria sets, physician documentation, observations, and/or conversations with the attending physician are performed by Care Management Program staff.

Reviews may be focused on certain selected diagnoses and procedures with identified or suspected utilization related problems, regardless of payer type. All reviews will address over- and under-utilization as well as ineffective use and scheduling of resources.

A. Preadmission review (42 CFR 456.127)

i. On selected occasions, review and final decision prior to the patient's admission may be accomplished for certain providers or categories of admission identified by the URC and/or Care Management Program staff as potential utilization issues. This may include patients accessing inpatient services through the emergency department, direct admits and/or transfers from other facilities.

ii. If the pre-admission review does not meet established criteria, the case will first be discussed with the attending physician to explore alternate level of care services and, if necessary, forwarded to the Medical Advisor, Care Management Program.

iii. If needed, the case is elevated to the applicable physician chief of the particular service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient before he/she is formally admitted to the hospital and the hospital has reason to believe the admission will not be covered by Medicare or other payer.

B. Admission review (42 CFR 456.60, 4565.121 - 126 & 129)

i. All inpatient admissions shall be reviewed for appropriateness for inpatient level of care by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

ii. In cases of seemingly non-qualified admission, once the initial screening criteria are applied, the Medical Advisor or another physician will provide second-level medical/physician review. Such physicians may be other physicians on the URC, non-URC physicians on the medical staffs of hospitals in the STHe system, and/or

other non-URC physician advisors of external resources and vendors.

C. Continued stay (42 CFR 456.128 - 137)

i. Continued stay reviews are based on established guidelines, such as those developed by "Interqual" criteria.

ii. A more focused review may be used for cases that, by experience, have been associated with high cost, frequent use of excessive services, or are attended by a physician whose patterns of care have caused quality of care or safety concerns.

iii. If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

iv. If needed, the case is elevated to the attention of the applicable physician chief of service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient per direction of the URC.

D. Second Level Physician Review for Inpatient Level of Care

i. If the Care Management Program case management staff determine by first-level screening criteria that a patient's inpatient admission is not appropriate or continuing care is no longer consistent with medical management at the in-patient level, the case will be referred to the hospital's Utilization Review Committee or a subgroup thereof, which contains at least one (1) physician member of the URC, which may be the Medical Advisor of the Care Management Program. or other designated physicians and/or physician advisors.

Second level reviews performed by physicians who are not on the Utilization Review Committee will be considered as advisory in nature. A physician member of the URC must review and agree with all reviews performed by non-URC physician members. The judgment and recommendation of the URC member shall be the action taken.

In the latter event of such second-level physician review, if the physician performing second-level review has reason to believe the admission or continued stay is not necessary or no longer medically appropriate at the in-patient level, he/she will attempt to contact the attending physician and afford him/her an opportunity to discuss the case or situation in question. In such situations, the attending physician's judgment and opinion is given considerable weight. If the attending physician concurs that inpatient admission is not appropriate or medical necessity for continued stay does not exist, the attending physician will treat the patient at a lower level of care or discharge the patient. In the situations where inpatient admission is not appropriate, the Hospital shall follow the procedures applicable for Condition Code 44 or the applicable denial of benefits procedure.

ii. If, however, the attending physician does not concur with the determination made by the Medical Advisor or other physician member of the UR Committee, the case

will be referred to at least one other physician member of the Utilization Review Committee for case review. In such situations, the attending physician's judgment is once again given considerable weight. If this additional second physician review indicates justification for admission/ continued stay, the admission or continued stay will be deemed medically appropriate.

If the two physician members determine that the patient's inpatient admission/stay is not medically necessary or appropriate, their determination becomes final, and the attending physician shall be informed of such; the Hospital follows the applicable denial of benefits procedure or the procedures applicable for Condition Code 44. The determination of the URC member(s) shall be documented in the patient's record.

It should be noted that in such situations, Hospital care is not being denied, however, the patient (and/or insured) will be informed of any potential financial liability for non-covered services. The Director of Care Management or designee will provide written notice of such to the patient and/or patient representative when the determination is made that the patient's care is not appropriate at the inpatient level. Copies will be distributed to the hospital, the state agency for Medicare patients (if applicable), the attending physician and any other appropriate reviewing organization no later than 2 days after such final decision.

E. Extended Stay Reviews

Cases of long length of stay and/or high cost will also be reviewed by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

The procedures for second-level physician review as specified in **V. D** above ("Second Level Physician Review for Inpatient Level of Care") shall apply for such extended stay reviews.

F. Discharge Readiness

i. Early discharge planning is an important aspect in the efficient use of available health care services and in the protection of our patients against the risks of hospitalization. The case manager is responsible for coordinating the efforts of the multidisciplinary team for planning a patient's discharge. In order to facilitate and accomplish a smooth and safe discharge from acute care to the appropriate level, the attending physician will work in conjunction with the Case Manager and staff of the Care Management Program to assure that post-acute care needs have been addressed by the time discharge occurs.

VI. PATIENT INFORMATION REQUIRED FOR UTILIZATION REVIEW

Each patient's record must include specific information needed to efficiently perform the UR function. This information shall include, but not be limited to accurate identification of the patient; name of the patient's attending physician; name of the patient's third party insurer (when applicable); date of admission; the documented plan of care; date of operation or procedure; the justification of an emergency admission (when applicable); and other supporting documentation that the URC believes appropriate to be include for the determination process.

VII. ACCEPTANCE AND APPROVAL

_____ _____

Chairman, Medical Executive Committee

_____ _____

President, Chief Executive Officer

Reference: Code of Federal Regulations Title 42, Part 456 and Part 482

Written: March 6, 2007

Revised: May 20, 2007	April 23, 2009	March 26, 2012
June 22, 2007	July 27, 2009	
July 11, 2007	February 19, 2012	

April 26, 2013

Tab 19

Attachment C
Contribution to the Orderly Development of Health Care – 5

Patient Bill of Rights

Baptist Hospital

A member of Saint Thomas Health

Effective Date:	*04/2013*
Last Reviewed:	*04/2013*
Last Revised:	*04/2013*
Expiration Date:	*04/2016*
Owner:	*Thompson, Dr. Bill: Chief Quality Officer*
Section/Dept:	*Rights and Responsibilities of the Individual*
References:	
Applicability:	*Saint Thomas Health*

Patient Rights and Responsibilities

Hospital care is a special partnership between patients, their loved ones, physicians and hospital staff. We at Saint Thomas Health respect your rights, values and dignity, and we ask that you recognize the responsibilities that come with being a patient in our hospitals. Please review these rights and responsibilities and discuss them with your caregivers and your family.

Patient Rights:

- You have the right to safe, high quality, compassionate healthcare, without fear of discrimination of any kind.
- You have the right to the most appropriate medical treatment available, delivered in a safe, considerate, and respectful manner.
- You have the right to have your illness, treatment, alternatives and outcomes explained in a manner and language you can understand, including the use of interpretation services as needed.
- You or your personal representative has the right to participate in the development and implementation of your plan of care.
- You have the right to make informed decisions about your care in collaboration with your physician and other caregivers. You have the right to accept or refuse medical care, including life sustaining and resuscitative treatment, to the extent permitted by law. You have the right to be informed of the medical consequences of your decisions.
- You have the right to receive professional assessment and management of your pain.
- You have the right to know the identity and professional status of persons caring for you, and the right to refuse to be treated by a student. You have a right to request a second opinion.
- You have the right to complete, ongoing information concerning your diagnosis, treatment, and any known prognosis. You have the right to information on post-discharge care needs and alternatives, including transfers to another facility.
- You have the right to assistance with and to participate in the consideration of ethical issues that may arise in the course of your care.
- You have the right to know what hospital rules and regulations apply to you as a patient
- You have the right to refuse experimental treatment or drugs.
- You have the right to private and confidential treatment/personal care, communications and medical records to the extent permitted by law.
- You have the right to have information regarding your medical treatment explained to your family member or other appropriate individual when you are unable to participate in decisions about your care.

- You have the right to receive information about and assistance with advance directives, (Living Will/ Advance Care Plan; Durable Power of Attorney for Healthcare/ Surrogate Decision Maker for Healthcare/Physician Orders for Scope of Treatment), which may include delegation of the right to make decisions about your care to a personal representative, as well as designation of a support person. You have the right to review and revise existing directives, and to have your advance directives respected within the limits of the law.
- You have the right to have your wishes regarding organ donation honored. You have the right to have your treatment preferences honored and to receive the same level of care whether or not you have written advance directives.
- You have the right to access the information in your medical records within a reasonable timeframe. You have the right to request amendments to your medical record. You have the right to receive an accounting of disclosures of your medical information, within the limits of the law.
- You have the right to examine an itemized copy of your hospital bill and to have it explained to you, regardless of source of payment. You also have the right to information concerning possible resources for financial assistance.
- You have the right to care that is provided in the least restrictive way, and to have restrictions such as restraints or seclusion explained and reviewed.
- You have the right to be free from all forms of abuse, neglect and exploitation, and the right to access protective or advocacy services when indicated or required.
- You (or your support person) have the right to be informed of your visitation rights including any clinical restrictions or limitations of our rights.
- You have the right to receive visitors designated by you, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.
- You have the right to visitation privileges that are not restricted, limited, or denied based upon race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. All your visitors shall enjoy full and equal visitation privileges.
- You have the right to the presence of a support individual of your choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be your surrogate decision maker or legally authorized representative.

Patient Responsibilities:

- You are responsible for providing the hospital with all necessary information about your medical history, hospitalizations, medications, and other matters related to your health.
- You are responsible to communicate with those involved in your care, including asking questions if medical information or instructions are not clear to you.
- You are responsible for following your plan of care. If you are unable or unwilling to follow the plan of care, you are responsible for telling your care provider. Your care provider will explain the medical consequences of not following the recommended treatment. You are responsible for the outcomes of not following your plan of care.
- You are responsible to respect your caregivers' efforts to provide care and treatment to other patients.
- You are responsible for following the hospital's rules and regulations, to act in a manner that is respectful of other patients, staff and hospital property, and to ask that your visitors do the same.
- You are responsible to provide the hospital with a copy of your advance directive, and to inform your family or preferred decision maker about your wishes and the location of any advance directives.

- You are responsible to provide the hospital with financial and health insurance information necessary to process your bill, and to meet your financial obligations to this facility.

Complaint Resolution:

We want to hear from you. You and your family have the right to voice your compliments, concerns and complaints freely without fear of coercion, discrimination, reprisals, or unreasonable interruptions of care. Your concerns and complaints will be reviewed and resolved when possible, and grievances will be responded to within seven (7) working days. You may voice your concerns with your caregivers, or you may call one of the following Complaint Lines:

Baptist Hospital (615) 284-4438 or 5275
Hickman Hospital (931) 729-4271
Middle Tennessee Medical Center (615) 396-5934
Saint Thomas Hospital (615) 222-6630

If you do not feel your complaint was handled properly, please call one of the following numbers:

Tennessee Department of Health, Health Facilities Complaint Hotline 1-877-287-0010
Joint Commission Complaint Hotline 1-800-994-6610

All revision dates:	04/2013
Attachments:	No Attachments

Tab 20

Attachment C
Contribution to the Orderly Development of Health Care - 7.(b)

The Joint Commission Documentation

The Joint Commission

October 20, 2011

Bernard Sherry, BS, MHA
CEO/President
Baptist Hospital
2000 Church Street
Nashville, TN 37236

Joint Commission ID #: 7884
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 10/20/2011

Dear Mr. Sherry:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning April 09, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

Tab 21

Attachment C
Contribution to the Orderly Development of Health Care - 7.(c)

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000032

No. of Beds 0683

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SETON CORPORATION *to conduct and maintain a*

Hospital BAPTIST HOSPITAL

Located at 2000 CHURCH STREET, NASHVILLE

County of DAVIDSON *, Tennessee.*

This license shall expire APRIL 30 *,* 2014 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 30TH *day of* APRIL *,* 2013 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner MD
COMMISSIONER

000231

DCF011

Tab 22

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Inspection Report

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820		

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A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

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A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53132	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial During complaint investigation of #30296, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

Tab 23

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Plan of Corrective Action

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395	For current and future patients new triggers have been added to our computerized medical record system which triggers an individualized care plan to include diabetes education and insulin education based on individual experience with insulin use. As for patients that may have been affected in the past, a random audit of known diabetics over the past six months will be conducted seeking patients who have been discharged with new prescriptions of insulin. Five per month will be examined unless the total new insulin patients is less then 5 in a given month. If documented education is not found, patients will be given appointments with the Diabetes Center for education at no charge. Education for all nurses regarding individualizing care plans for diabetics is in process (began 9/28/12) with extended deadline to cover nurses who may be on leave of absence.	9/25/12 10/19/12 11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395	Concurrent audits of diabetic patients by the Diabetes center nurses for a period of six months. Audits will include monitoring care plans, will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk. Discharge planning for patients regarding diabetes will be initiated with admission assessment and will be incorporated within the care plan including insulin teaching for the patient, significant others, and home caregivers. This will include return demonstrations. Depart process includes triggers for education of patients and significant others regarding injectable insulin including return demonstration and written materials to take home. The Diabetes Center nurses are also available to assist.	10/8/12 - 4/8/2013 9/25/12 9/25/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820	Education for all nurses regarding diabetic patient discharge instructions, return demonstration of insulin administration by patient and significant other is currently in process and will be extended to allow for nurses on leave of absence. Concurrent audits by Diabetes Center nurses regarding depart diabetes education, return demonstration if going home with new injectable insulin prescriptions for a period of 6 months. Will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk.	11/30/12 10/8/12 - 4/8/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820	Diabetes Center was not asked to consult on this patient. Normal triggers for diabetes educators include blood sugars >180 and A1C >8. Neither applied in this situation. The electronic medical record system will now include a prompt for nursing to consult Diabetes Educator if necessary to ensure all patients are evaluated and educated.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53132	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial During complaint investigation of #30295, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

October 31, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

RE: 44-0133

Dear Mr. Sherry:

The East Tennessee Region of Health Care Facilities conducted a complaint investigation on September 4, 2012. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all participation requirements as of October 19, 2012.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely.

Karen B. Kirby/kg

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN00030295

Attachment D

Copy of Published Public Notice
Letter of Intent

Tab 24

Attachment D

Copy of Published Public Notice

Trustee.
The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.
Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-050533

0101663110

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **July 30, 2013 at 10:00AM local time,** at the Davidson County Courthouse, South Main door, One Public Square, Nashville, Tennessee pursuant to Deed of Trust executed by Carlos D. Meriwether and

Continued to next column

pointed Substitute or Successor Trustee, all of record in the Davidson County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, NA
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:
Being Lot No. 50, on the Plan of the Resubdivision of Lot 1 Forge Ridge, of record in Plat Book 9700, pages 295 and 296, Register's Office for Davidson County, Tennessee, to which plat reference is hereby made for a more complete description.
Street Address: 104 Forge Ridge Court, Nashville, Tennessee 37217
Parcel Number: 135 06 0A 050.00
Current Owner(s) of Property: Carlos D. Meriwether and Jada J. Meriwether
The street address of the above described property is believed to be 104 Forge Ridge Court, Nashville, Tennessee 37217, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
This sale is subject to all matters shown

Continued to next column

ises might disclose.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.
Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-048196

B. Denton, Trustee, as trustee for Mortgage Electronic Registration Systems, Inc. ("MERS"), solely as nominee for Primelending, a Plainscapital Company on April 5, 2010 at Instrument No. 20100420-0029690; conducted by Shapiro & Kirsch, LLP having been appointed Substitute or Successor Trustee, all of record in the Davidson County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, NA
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:
Land in Davidson County, Tennessee, being Lot No. 86 on the Plan of Oakwood Terrace, Section II, of record in Book 4460, Page 118, Register's Office for said county, to which plan reference is hereby made for a more complete description.
Street Address: 4533 Xavier Drive, Antioch, Tennessee 37013
Parcel Number: 148 08 0 110.00
Current Owner(s) of Property: Roberto Casarias Calderin and wife, Marlen Nunez Cruz
The street address of the above described property is believed to be 4533 Xavier Drive, Anti-

Continued to next column

any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or en-

Continued to next column

Trustee.
The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and

Continued to next column

0101666799

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Seton Corporation d/b/a Baptist Hospital, an existing acute care hospital owned by Seton Corporation with an ownership type of not-for-profit and to be managed by Seton Corporation d/b/a Baptist Hospital intends to file an application for a Certificate of Need for the replacement and relocation of four operating rooms at Baptist Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Baptist Hospital will not change as a result of this project. Renovations will be made to 17,842 square feet of space and there will be no new construction. The total project costs are estimated to be $11,499,496.
The anticipated date of filing the application is: July 15, 2013. The contact person for this project is Barbara Houchin, Executive Director, Planning, who may be reached at Saint Thomas Health, 102 Woodmont Blvd., Suite 800, Nashville, Tennessee, 37205, 615-284-6849.
Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:
Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243
The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

may be rescinded by the Substitute Trust-

Continued to next column

Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 12-031780

0101666913

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Baptist Plaza Surgicare, an existing Ambulatory Surgical Treatment Center (ASTC), owned by: Baptist Plaza Surgicare, L.P. with an ownership type of limited partnership and to be managed by: United Surgical Partners International, Inc., intends to file an application for a Certificate of Need for: the relocation of the existing ASTC with nine (9) outpatient surgery operating rooms, and one (1) surgical procedure suite. Construction of approximately 28,500 rentable square feet of space in a new medical office building will be required. The existing facility is located at 2011 Church Street, Medical Plaza I Lower Level, Nashville, TN 37203 (Davidson County). The proposed facility will be located at the northeast corner of the intersection of Church Street and 20th Avenue North, Nashville, TN, 37203 (Davidson County). The total cost of the project is estimated to be $29,836,377 (based upon sum of lease payments for initial 20 year term).
The anticipated date of filing the application is July 15, 2013. The contact person for this project is Corey Ridgway, Market President, who may be reached at United Surgical Partners International, Inc., 8 Cadillac Drive, Suite 200, Brentwood, TN, 37027, 615-376-7300.
Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:
Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243
The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

0101666927

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $200,000.00.
The anticipated date of filing the application is: July 15, 2013.
The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at 2021 Richard Jones Road, Suite 350, Nashville, Tennessee, 37215, 615/370-3380.
Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:
Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243
The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

000258

Continued from last column

AT RECORD BOOK 2883, PAGE 424, IN THE REGISTER'S OFFICE OF DAVIDSON COUNTY, TENNESSEE.
All right of equity of

Continued from last column

wife, Jada J. Meriwether, to American Title Company, Inc., Trustee, as trustee for Mortgage Electronic Registration Systems.

Continued from last column

on any applicable recorded plat; any unpaid taxes; and any restrictive covenants, easements or setback lines that may be applicable;

Continued from last column

0101664994

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **September 3, 2013** at

Continued from last column

och, Tennessee 37013, but such address is not part of the legal description of the property sold herein and in the event of any dis-

Continued from last column

cumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose.

Continued from last column

place for the sale set forth above. If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale,

Continued from last column

ee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information ob-

Tab 25

Attachment D

Letter of Intent

2013 JUL 15 AM 10 11

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson County (County), Tennessee, on or before July 10 (Month / day), 2013 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Seton Corporation d/b/a Baptist Hospital (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Seton Corporation with an ownership type of not-for-profit

and to be managed by: Seton Corporation d/b/a Baptist Hospital intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the replacement and relocation of four operating rooms at Baptist Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Baptist Hospital will not change as a result of this project. Renovations will be made to 17,842 square feet of space and there will be no new construction. The total project costs are estimated to be $11,499,496.

The anticipated date of filing the application is: July 15, 2013

The contact person for this project is Barbara Houchin (Contact Name), Executive Director, Planning (Title)

who may be reached at: Saint Thomas Health (Company Name), 102 Woodmont Blvd., Suite 800 (Address)

Nashville (City), TN (State), 37205 (Zip Code), 615-284-6849 (Area Code / Phone Number)

Barbara Houchin (Signature), 7/9/2013 (Date), bhouchin@stthomas.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY-
Application
Saint Thomas Midtown Hospital FKA Baptist Hospital
CN1307-028

Ascension Health Ministry SVC CTR
4040 Vincennes Circle
Indianapolis, IN 46268
317-334-VEND (8363)

THIS DOCUMENT CONTAINS SECURITY FEATURES — SEE BACK FOR DETAILS

335535

60-160
433

The Bank of New York Mellon
Pittsburgh, Pennsylvania

Date Jul/08/2013

Pay ***TWENTY-FIVE THOUSAND EIGHT HUNDRED SIXTEEN AND XX/100 DOLLARS***

To The Order Of
TN HEALTH SVCS
500 DEADERICK ST STE 850
NASHVILLE, TN 37243

VOID AFTER 90 DAYS

Authorized Signature

Authorized Signature

Authorized Signature

THANK YOU FOR YOUR PAYMENT

Health Services and Dev Agency
Office 31607001

Receipt #: 10384506
Batch #: 509362
Trans #: 3
PAID: 7/15/2013

HA01 CON Filing Fees $25,816.00

Pay Amount $25,816.00**

$25,816.00

$25,816.00

STATE OF TENNESSEE
Health Services and Dev Agency
Office 31607001
7/15/2013 9:45 AM

Cashier: annlr0811001
Batch #: 509362
Trans #: 3
Workstation: AF0719WP45

CON Filing Fees

Receipt #: 10384506
HA01 CON Filing Fees $25,816.00
Payment Total: $25,816.00

Transaction Total: $25,816.00

Check 21 $25,816.00

Thank you for your payment.
Have a nice day!

CN1307-028

Baptist Hospital

A member of Saint Thomas Health

THE RELOCATION AND EXPANSION OF FOUR OPERATING ROOMS AT BAPTIST HOSPITAL

CERTIFICATE OF NEED APPLICATION
JULY 2013

Saint Thomas Health

2013 JUL 15 AM 10 07

July 12, 2013

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

RE: Baptist Hospital CON Application

Dear Melanie:

Please find the enclosed application for a certificate of need for Baptist Hospital proposing to develop an orthopedic surgery suite as a consolidation and relocation of existing operating rooms.

As you have heard in the news, Saint Thomas Health has renamed its member hospitals in Middle Tennessee to reflect the organization's common mission. Effective July 11, 2013, Baptist Hospital is Saint Thomas Midtown Hospital owned by a non-profit corporation with the same name (formerly Seton Corporation d/b/a Baptist Hospital).

Preparation of this application has been in process way in advance of this name change, including submission to the newspaper for the public notice prior to the name change. As a result, the application as prepared does not reflect the new name.

Please let me know if there is anything else I need to do around notification of the name change or if you have any questions.

Respectfully,

Barbara Houchin

Barbara Houchin
Executive Director, Planning

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A."* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** *certificate of corporate existence, if applicable, from the Tennessee Secretary of State.*

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

1. ***Name of Facility, Agency, or Institution***

Seton Corporation d/b/a Baptist Hospital
Name

2000 Church Street
Street or Route

Davidson
County

Nashville — TN — 37236
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Barbara Houchin — Executive Director, Planning
Name — Title

Saint Thomas Health — bhouchin@stthomas.org
Company Name — email address

102 Woodmont Boulevard, Suite 800 — Nashville — TN — 37205
Street or Route — City — State — Zip Code

Executive Director, Planning — 615-284-6849 — 615-284-7403
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

Seton Corporation — 615-284-6869
Name — Phone Number

102 Woodmont Blvd, Suite 800 — Davidson
Street or Route — County

Nashville — TN — 37205
City — ST — Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	F.	Governmental (State of TN or Political Subdivision)
B.	Partnership	G.	Joint Venture
C.	Limited Partnership	H.	Limited Liability Company
D.	Corporation (For Profit)	I.	Other (Specify)
E.	Corporation (Not-for-Profit) X		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. ***Name of Management/Operating Entity (If Applicable)***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City ST Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) Acute Care	X	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)	
			Q.	Other (Specify) _____	

8. **Purpose of Review** ***(Check as appropriate--more than one response may apply)***

A.	New Institution		G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Significant Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____		H.	Change of Location	
E.	Discontinuance of OB Services		I.	Other (Specify)_____	
F	Acquisition of Equipment				

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds		Staffed Beds	Beds Proposed	TOTAL Beds at Completion
		Licensed	*CON			
A.	Medical	355		147		355
B.	Surgical (General Med/Surg)	102		96		102
C.	Long-Term Care Hospital					
D.	Obstetrical	104		97		104
E.	ICU/CCU	46		37		46
F.	Neonatal	52		52		52
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation	24		24		24
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	683		453		683

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 044-0133
Certification Type Acute Care Hospital

11. **Medicaid Provider Number** 044-0133
Certification Type Acute Care Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or *plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: Baptist Hospital participates in the major TennCare MCOs serving the majority of the patients in the area: Americhoice and Amerigroup. In total, Baptist Hospital participates in approximately 44 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which Baptist Hospital participates.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Please see the following executive summary.

CARDIAC AND MEDICAL IMAGING RENOVATIONS
REPLACEMENT OF TWO PET UNITS WITH ONE PET/CT

APPLICANT OVERVIEW: For more than 90 years, Baptist Hospital has been devoted to physical, emotional and spiritual healing. Baptist Hospital is the largest not-for-profit community hospital in Middle Tennessee, licensed for 683 acute and rehab care beds. Baptist Hospital's heritage of healing is one of continuous growth, community service and superior care. Recent achievements in clinical care include:

- Nation's 100 Top Hospitals by Thomson Reuters and 100 Top Hospitals Everest Award
- 2010 HealthGrades Hospital Quality in America Study -- selected results for cardiac care
  - Five-star rated for Coronary Bypass Surgery
  - Ranked among the top 3 hospitals in Tennessee for Cardiac Surgery
  - Ranked among the top 5 hospitals in Tennessee for Overall Cardiac Care
  - Ranked best in Nashville for Overall Cardiac Care
- Three-Year Approval with Commendation from the Commission on Cancer of the American College of Surgeons
- Accredited by the American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC) - First in Middle Tennessee
- Certification Mark for ACR Breast Imaging Centers of Excellence (BICOE)

PROPOSED SERVICES AND EQUIPMENT: Baptist Hospital is not proposing any new services or CON reviewable equipment. As described more fully in the need section below, this project involves the consolidation, relocation and expansion of four existing orthopedic operating rooms into an orthopedic surgery suite. To stage the project, it will be necessary to renovate an existing nursing floor of the hospital, located on the eighth floor. Baptist Hospital will redistribute the displaced beds on the nursing floor throughout the hospital and, therefore, the hospital's licensed bed capacity will not change. The project includes renovation of approximately 17,842 square feet, which will consolidate four of Baptist Hospital's orthopedic operating rooms into an orthopedic surgery suite with dedicated PACU and Prep/Recovery area.

OWNERSHIP STRUCTURE: Baptist Hospital, owned by Seton Corporation, is a member of Nashville-based Saint Thomas Health, which is part of Ascension Health. Ascension Health is a Catholic organization that is the largest not-for-profit health system in the United States. Other members of Saint Thomas Health include Saint Thomas Hospital in Nashville, Middle Tennessee Medical Center in Murfreesboro and Hickman Community Hospital in Centerville. The proposed project will not result in a change in ownership structure.

SERVICE AREA: Based on historical patient origin data, Baptist Hospital's service area for this project is comprised of 12 counties in Middle Tennessee. As reported in the hospital's FY2012 patient origin data, this 12-county area represents 89.5% of Baptist Hospital's inpatient discharges.

Cheatham	Humphreys	Rutherford
Davidson	Maury	Sumner
Dickson	Montgomery	Williamson
Hickman	Robertson	Wilson

NEED: Baptist Hospital needs to consolidate and expand its orthopedic operating rooms to improve operational efficiency, provide rooms that are large enough to accommodate imaging equipment and larger operating table, and enhance the overall quality of orthopedic surgery services. Achieving these objectives was instrumental in Baptist Hospital's decision to proceed with this project.

- Improve patient flow and operational efficiency: The orthopedic operating rooms are not centrally located, which creates poor patient flow and operational inefficiencies. Four of Baptist Hospital's orthopedic operating rooms, which the hospital primarily utilizes for joint replacement and fracture surgeries, are located on the fourth floor (two operating rooms) and seventh floor (two

operating rooms) of the hospital. Because the operating rooms are not in a single location, it is difficult to maximize physician and staff productivity as well as provide efficient and seamless patient flow. By consolidating the fourth and seventh floor orthopedic operating rooms on the eighth floor of the hospital with a dedicated PACU and Prep/Recovery, Baptist Hospital will be able to enhance operational efficiency and staff productivity. In addition, inpatient surgical patients will be cared for on an adjacent nursing unit, which should further enhance patient flow and care coordination.

- Provide operating rooms large enough to accommodate needed imaging equipment and larger operating table: Currently, Baptist Hospital operates four orthopedic surgery operating rooms that are undersized. These rooms cannot accommodate the imaging equipment and larger operating tables that are required for more complex orthopedic procedures such as joint replacement, which are important and growing needs for an aging population. The current standard for orthopedic operating rooms is approximately 600 square feet. Baptist Hospital's orthopedic operating rooms measure approximately 333 to 510 square feet and do not provide adequate space.

- Improve quality of care: Consolidating the orthopedic operating rooms into an orthopedic surgery suite on the eighth floor will improve the overall quality of orthopedic care provided by Baptist Hospital. The improvements in patient flow with orthopedic surgery located on a single floor will enhance the patient experience. The "single floor" experience will allow Baptist Hospital to improve staff collaboration and care coordination throughout the patient's entire episode of care from admissions to discharge. In addition, with larger operating rooms, Baptist Hospital's orthopedic surgeons will be able to perform more procedures that are complex by having the benefits of needed imaging equipment and larger operating tables in the operating rooms.

EXISTING RESOURCES: Currently, Baptist Hospital offers a continuum of surgical services, including orthopedic surgery, and it will continue to do so. The proposed project will not result in Baptist Hospital terminating any services; it will only result in the consolidation and enhancement of its orthopedic operating rooms.

PROJECT COST: The total estimated cost of the proposed project is $11,499,496. Project costs include $6,054,931 for renovation (includes demolition and construction contingency costs) of 17,842 square feet ($339.36 per square foot or $303.21 per square foot excluding demolition). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

FUNDING: Baptist Hospital will fund the project through its unrestricted cash reserves.

FINANCIAL FEASIBILITY: Baptist Hospital expects that construction and renovations will be completed and the project operational by July 2014. Projections for FY2015 and FY2016 indicate that the project is financially feasible. As explained below, this project is being proposed in order to improve access to care, economic efficiencies and quality of care without increasing charges to government and third-party payors.

STAFFING: This project will require a modest increase in staff, approximately 5.7 additional FTEs, which will include a combination of RNs and surgical techs. Baptist Hospital's salaries and wages are competitive with the market. Baptist Hospital has a history of successfully recruiting and retaining professional and administrative staff.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: This project involves the relocation and consolidation of Baptist Hospital's four orthopedic operating rooms, which the hospital utilizes primarily for joint replacement surgery and fracture surgery. These operating rooms are now located on the fourth (two operating rooms) and seventh (two operating rooms) floors of the hospital and will be relocated to a new orthopedic surgery suite on the eighth floor. In addition to the replacement of the four orthopedic operating rooms, the proposal includes shelled construction of two additional operating rooms that Baptist Hospital will build out and utilize later to meet future demand. Other components of the project include the construction of a nine-bed PACU and a 10-bed Prep/Recovery. The relocation of the four operating rooms will be a replacement of existing rooms and will not result in an increase in the hospital's current number of operating rooms. To accommodate the four new operating rooms and not increase the hospital's total number of operating rooms, Baptist Hospital will close four existing rooms until such time that it determines an appropriate use of the space.

The four operating rooms will measure between 585 square feet and 600 square feet with the shelled rooms measuring 595 square feet and 585 square feet. The PACU will measure approximately 90 square feet per bed and the Prep/Recovery will measure approximately 120 square feet per bed. Total renovation will be approximately 17,842 square feet for the eighth floor orthopedic surgery suite, which includes 1,000 square feet for the mechanical penthouse. Total construction costs, including demolition and construction contingency, will be $6,054,931 or approximately $339.36 per square foot ($303.21, not including demolition), which compare favorably to other similar Tennessee projects.

To accommodate the consolidation of the orthopedic operating rooms, 30 beds on the eighth floor will relocated and redistributed to available space in the hospital. Therefore, at the completion of the project Baptist Hospital will continue to be licensed for 683 beds.

No temporary relocation is required.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: Not applicable. The proposed project does not affect the bed complement at the hospital.

Square Footage Exhibit

Unit/Dept.	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.		
					Renovated	New	Total	Renovated	New	Total
OR #1 - Class C, Ortho Major	7th Floor	333	N/A	8th Floor	585	N/A	585	$450	N/A	$450
OR #2 - Class C, Ortho Major	7th Floor	333	N/A	8th Floor	585	N/A	585	$450	N/A	$450
OR #3 - Class C, Ortho Major	4th Floor	510	N/A	8th Floor	585	N/A	585	$450	N/A	$450
OR #4 - Class C, Ortho Major	4th Floor	510	N/A	8th Floor	585	N/A	585	$450	N/A	$450
OR Support	N/A	N/A	N/A	8th Floor	9,883	N/A	9,883	$175	N/A	$175
PACU/Support	N/A	N/A	N/A	8th Floor	2,799	N/A	2,799	$290	N/A	$290
Prep/Recovery Support	N/A	N/A	N/A	8th Floor	2,820	N/A	2,820	$275	N/A	$275
Unit/Dept GSF Sub-Total		1,686	N/A		17,842		17,842	$259	N/A	$259
Mechanical/Electrical GSF	Mechanical Penthouse		N/A							
Circulation/Structure GSF			N/A							
Total GSF		1,686	N/A		17,842		17,842	$259	N/A	$259

Note: Does not include demolition and construction contingency.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: Not applicable. Baptist Hospital is not requesting a new services or additional pieces of major medical equipment. Baptist Hospital will relocate, consolidate and enlarge four of its orthopedic operating rooms while developing an orthopedic surgery suite, primarily for joint replacement and fracture surgery, on the eighth floor of the hospital.

D. Describe the need to change location or replace an existing facility.

RESPONSE: Currently, the operating rooms that Baptist Hospital's utilizes primarily for joint replacement and fracture surgery are not located in a single area, which creates operational problems with patient flow and staff productivity. In addition, the operating rooms are undersized, which does not allow the hospital's orthopedic surgeons to perform complex procedures that require imaging equipment and larger operating table in the operating room. Expanding the operating rooms in their current locations is not a desirable alternative. Expansion in the current location does not address the operational problems that arise with the operating rooms being located in different parts of the hospital. In addition, expanding the operating rooms without relocating them requires that the current rooms be inoperable during the project, which will significantly disrupt services. Relocating the orthopedic surgery operating rooms to a self-contained orthopedic surgery suite with dedicated PACU and Prep/Recovery will offer a number of important benefits to the patient, physician and the hospital. The consolidation will address the current operational problems that arise with having the operating rooms dispersed in multiple locations. In addition, relocating the operating rooms will allow Baptist Hospital to continue to provide orthopedic surgery services in the exiting operating rooms while the project is complete. At the completion of the project, Baptist Hospital will be able to make a smooth and seamless transition from the old operating rooms to the new orthopedic surgery suite.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal

lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:
      1. Total cost; (As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

   b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable, as Baptist Hospital is not proposing to acquire any single piece of major medical equipment that exceeds $1.5 million or is a MRI, PET, extracorporeal lithotripter or linear accelerator.

2. For mobile major medical equipment:

   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment; and
   e. List the owner for the equipment.

RESPONSE: Not applicable.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable.

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: Please see **Attachment B, III.(A) (Tab 7)** that depicts the 38-acre site.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: Baptist Hospital is conveniently located in Nashville just off State Route 70

near two Interstate Highways, I-40/65 and I-440. The hospital is accessible via public transportation services offered by the Nashville Metro Transit Authority, providing direct access to the hospital. The hospital is within 10 miles of the Nashville International Airport.

Please see **Attachment B, III.(B).1 (Tab 8)** for a map depicting the service area and the thoroughfares that connect each county to the proposed site, as well a map of the Nashville MTA service.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see **Attachment B, IV (Tab 9)** for the floor plan schematics.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. The project does not involve a Home Health Agency or Hospice.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

      RESPONSE: Not applicable. This project does not include any new services or equipment that is reviewable under a specific set of criteria and standards. Baptist Hospital proposes to consolidate and expand four of its orthopedic operating rooms. Specifically, its project will relocate four existing orthopedic operating rooms, which are located on the fourth and seventh floors of the hospital to an orthopedic surgery suite on the eighth floor of the hospital. In addition to the four relocated operating rooms, the suite will include two "shelled" operating rooms for future use, a nine-bed PACU and a 10-bed Prep/Recovery.

   b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

      RESPONSE: Not applicable. This project does not include a change of site for a health care institution.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

   RESPONSE: For more than 90 years, Baptist Hospital has been devoted to physical, emotional and spiritual healing. Baptist Hospital is the largest not-for-profit community hospital in Middle Tennessee, licensed for 683 acute and rehab care beds. Routine facility refurbishment is a necessary part of maintaining quality hospital services. This is especially critical in such key service line areas as orthopedic surgery. Baptist Hospital's proposal to consolidate and expand its orthopedic surgery service will help accomplish the following goals:

- Improve operational efficiency including enhanced patient flow and increased staff productivity
- Improve quality of care by expanding the size of the operating rooms to accommodate needed imaging equipment and operating room tables for complex orthopedic surgery cases
- Improve access to orthopedic services

These goals are also similar to the Five Principals for Achieving Better Health as articulated in the 2009 State Health Plan.

1. Healthy Lives. This project will improve the health of Tennesseans by improving clinical outcomes with modern orthopedic surgery facilities and providing a safer environment for patients by improving patient flow and care coordination.

2. Access to Care. This project will improve access to Baptist Hospital's orthopedic surgery services and allow Baptist Hospital to provide a broader range of complex surgeries that require in-room imaging equipment and larger operating tables.

3. Economic Efficiencies. This project will achieve operational efficiencies by replacing old, decentralized operating rooms with newer, state-of-the-art rooms that Baptist Hospital will operate within a centralized orthopedic surgery suite with dedicated PACU and Prep/Recovery. Patient flow and care coordination will be enhanced under a "single floor" concept that places orthopedic surgical services and orthopedic inpatient care on the same floor and contiguous to each other.

4. Quality of Care. In addition to the facility upgrades mentioned above, Baptist Hospital will continue to improve its quality of care through the adoption of best practices and data-driven evaluation. Realignment of the orthopedic surgery functions including admission, prep, procedure, recovery and discharge functions all on one floor is evidence of such efforts.

5. Health Care Workforce. Baptist Hospital is committed to the recruitment and retention of a sufficient and quality health care workforce. In recent years, Baptist Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Based on historical patient origin data, Baptist Hospital's service area for this project is comprised of 12 counties. As reported in the hospital's FY2012 patient origin data, this 12 county area represents 89.5 percent of Baptist Hospital's inpatient discharges. Please see **Attachment C, Need – 3 (Tab 10)** for a map and data (past three years) related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Baptist Hospital's primary service area is comprised of the 12 counties located in middle Tennessee, listed below.

Cheatham	Humphreys	Rutherford
Davidson	Maury	Sumner
Dickson	Montgomery	Williamson
Hickman	Robertson	Wilson

Between 2013 and 2018, the population of the service area is projected to increase by 5.6%, or by 104,204 residents. This represents an annual growth rate of 1.1% and is greater than the projected growth rate of the state within that same five-year period, which is 0.6% annually, or 3.2% total growth, and almost 50% greater than the rate of growth of the United States as a whole. Please see **EXHIBIT 1,** which illustrates the projected changes in population of the service area between 2013 and 2018 and denotes population growth within the Nashville MSA, the state of Tennessee, and the United States.

EXHIBIT 1
TOTAL POPULATION PROJECTIONS

	Total Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	645,722	675,767	30,045	0.9%	4.7%
Subtotal PSA	**645,722**	**675,767**	**30,045**	**0.9%**	**4.7%**
Secondary Service Area					
Cheatham	39,028	39,204	176	0.1%	0.5%
Dickson	50,556	52,121	1,565	0.6%	3.1%
Hickman	24,053	23,378	-675	-0.6%	-2.8%
Humphreys	18,381	18,299	-82	-0.1%	-0.4%
Maury	82,133	84,325	2,192	0.5%	2.7%
Montgomery	181,674	195,121	13,447	1.4%	7.4%
Robertson	68,061	70,933	2,872	0.8%	4.2%
Rutherford	276,375	296,297	19,922	1.4%	7.2%
Sumner	167,264	177,178	9,914	1.2%	5.9%
Williamson	194,928	211,426	16,498	1.6%	8.5%
Wilson	119,707	128,037	8,330	1.4%	7.0%
Subtotal SSA	**1,222,160**	**1,296,319**	**74,159**	**1.2%**	**6.1%**
Total Service Area	**1,867,882**	**1,972,086**	**104,204**	**1.1%**	**5.6%**
Nashville MSA	1,649,030	1,738,464	89,434	1.1%	5.4%
Tennessee	6,469,063	6,678,670	209,607	0.6%	3.2%
United States	314,861,807	325,322,277	10,460,470	0.7%	3.3%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the service area is much greater; almost four times that of the total growth. Between 2013 and 2018, projections indicate that the senior population will increase 23.0%, or by 49,262 residents. For Tennessee, projections are that the total five-year growth within this age cohort will be 17.5%, for the United States, 16.3%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for Baptist Hospital to anticipate increasing demand for services as result of this growth as well as that of the general population. Please see **EXHIBIT 2**.

EXHIBIT 2
65 AND OLDER POPULATION PROJECTIONS

	65+ Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	72,519	87,305	14,786	3.8%	20.4%
Subtotal PSA	**72,519**	**87,305**	**14,786**	**3.8%**	**20.4%**
Secondary Service Area					
Cheatham	4,865	5,998	1,133	4.3%	23.3%
Dickson	7,245	8,436	1,191	3.1%	16.4%
Hickman	3,642	4,053	411	2.2%	11.3%
Humphreys	3,418	3,853	435	2.4%	12.7%
Maury	11,610	13,787	2,177	3.5%	18.8%
Montgomery	15,803	19,498	3,695	4.3%	23.4%
Robertson	8,771	10,599	1,828	3.9%	20.8%
Rutherford	25,176	32,152	6,976	5.0%	27.7%
Sumner	23,114	28,257	5,143	4.1%	22.3%
Williamson	21,540	28,841	7,301	6.0%	33.9%
Wilson	16,235	20,421	4,186	4.7%	25.8%
Subtotal SSA	**141,419**	**175,895**	**34,476**	**4.5%**	**24.4%**
Total Service Area	**213,938**	**263,200**	**49,262**	**4.2%**	**23.0%**
Nashville MSA	192,949	237,358	44,409	4.2%	23.0%
Tennessee	939,436	1,104,190	164,754	3.3%	17.5%
United States	43,861,920	50,997,686	7,135,766	3.1%	16.3%

SOURCE: NIELSEN, INC.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: Baptist Hospital has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2013, the 65 and older population accounted for 11.5% of the total population in the service area. As a major demographic subgroup of Baptist Hospital's patient base, seniors will continue to expect of Baptist Hospital the same level of service while becoming an increasingly larger segment of the total service area population, with 2018 projections placing the 65 and older population at 13.3% of the total service area population.

The female population will represent 51.1% percent of the total population in the service area by 2018. As shown in **EXHIBIT 3**, the female population is expected to grow at the same annual rate as both sexes in service area, 1.1% per year.

EXHIBIT 3
FEMALE POPULATION PROJECTIONS

	Female Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	332,471	347,094	14,623	0.9%	4.4%
Subtotal PSA	**332,471**	**347,094**	**14,623**	**0.9%**	**4.4%**
Secondary Service Area					
Cheatham	19,562	19,711	149	0.2%	0.8%
Dickson	25,739	26,549	810	0.6%	3.1%
Hickman	11,433	11,120	-313	-0.6%	-2.7%
Humphreys	9,344	9,303	-41	-0.1%	-0.4%
Maury	42,376	43,453	1,077	0.5%	2.5%
Montgomery	92,613	99,400	6,787	1.4%	7.3%
Robertson	34,563	36,056	1,493	0.8%	4.3%
Rutherford	139,862	149,992	10,130	1.4%	7.2%
Sumner	85,639	90,728	5,089	1.2%	5.9%
Williamson	99,887	108,420	8,533	1.7%	8.5%
Wilson	61,117	65,466	4,349	1.4%	7.1%
Subtotal SSA	**622,135**	**660,198**	**38,063**	**1.2%**	**6.1%**
Total Service Area	**954,606**	**1,007,292**	**52,686**	**1.1%**	**5.5%**
Nashville MSA	842,361	887,657	45,296	1.1%	5.4%
Tennessee	3,314,336	3,419,717	105,381	0.6%	3.2%
United States	160,042,072	165,322,056	5,279,984	0.7%	3.3%

SOURCE: NIELSEN, INC.

EXHIBITS 4-6 illustrate the racial composition of the Baptist Hospital service area. By 2018, the white population will comprise 73.9% of the total population of the service area, while the black population will account for 16.1% and other races, 10.0%.

EXHIBIT 4
WHITE POPULATION PROJECTIONS

	White Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	388,461	393,651	5,190	0.3%	1.3%
Subtotal PSA	**388,461**	**393,651**	**5,190**	**0.3%**	**1.3%**
Secondary Service Area					
Cheatham	37,198	37,227	29	0.0%	0.1%
Dickson	46,269	47,496	1,227	0.5%	2.7%
Hickman	22,287	21,612	-675	-0.6%	-3.0%
Humphreys	17,472	17,395	-77	-0.1%	-0.4%
Maury	67,702	69,778	2,076	0.6%	3.1%
Montgomery	128,081	136,456	8,375	1.3%	6.5%
Robertson	59,290	61,602	2,312	0.8%	3.9%
Rutherford	211,267	218,359	7,092	0.7%	3.4%
Sumner	147,730	154,998	7,268	1.0%	4.9%
Williamson	173,213	186,428	13,215	1.5%	7.6%
Wilson	105,794	112,169	6,375	1.2%	6.0%
Subtotal SSA	**1,016,303**	**1,063,520**	**47,217**	**0.9%**	**4.6%**
Total Service Area	**1,404,764**	**1,457,171**	**52,407**	**0.7%**	**3.7%**
Nashville MSA	1,251,359	1,294,001	42,642	0.7%	3.4%
Tennessee	4,969,914	5,060,288	90,374	0.4%	1.8%
United States	225,086,154	228,212,180	3,126,026	0.3%	1.4%

SOURCE: NIELSEN, INC.

EXHIBIT 5
BLACK POPULATION PROJECTIONS

	Black Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	181,357	193,553	12,196	1.3%	6.7%
Subtotal PSA	**181,357**	**193,553**	**12,196**	**1.3%**	**6.7%**
Secondary Service Area					
Cheatham	557	544	-13	-0.5%	-2.3%
Dickson	2,026	1,951	-75	-0.8%	-3.7%
Hickman	1,082	1,028	-54	-1.0%	-5.0%
Humphreys	435	388	-47	-2.3%	-10.8%
Maury	9,887	9,357	-530	-1.1%	-5.4%
Montgomery	34,529	36,457	1,928	1.1%	5.6%
Robertson	4,839	4,609	-230	-1.0%	-4.8%
Rutherford	36,596	42,655	6,059	3.1%	16.6%
Sumner	10,949	11,890	941	1.7%	8.6%
Williamson	7,959	7,670	-289	-0.7%	-3.6%
Wilson	7,654	8,109	455	1.2%	5.9%
Subtotal SSA	**116,513**	**124,658**	**8,145**	**1.4%**	**7.0%**
Total Service Area	**297,870**	**318,211**	**20,341**	**1.3%**	**6.8%**
Nashville MSA	254,373	273,245	18,872	1.4%	7.4%
Tennessee	1,087,546	1,136,208	48,662	0.9%	4.5%
United States	40,007,260	41,797,400	1,790,140	0.9%	4.5%

SOURCE: NIELSEN, INC.

EXHIBIT 6
"OTHER" POPULATION PROJECTIONS

	"Other" Population				
	2013	2018	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	75,904	88,563	12,659	3.1%	16.7%
Subtotal PSA	**75,904**	**88,563**	**12,659**	**3.1%**	**16.7%**
Secondary Service Area					
Cheatham	1,273	1,433	160	2.4%	12.6%
Dickson	2,261	2,674	413	3.4%	18.3%
Hickman	684	738	54	1.5%	7.9%
Humphreys	474	516	42	1.7%	8.9%
Maury	4,544	5,190	646	2.7%	14.2%
Montgomery	19,064	22,208	3,144	3.1%	16.5%
Robertson	3,932	4,722	790	3.7%	20.1%
Rutherford	28,512	35,283	6,771	4.4%	23.7%
Sumner	8,585	10,290	1,705	3.7%	19.9%
Williamson	13,756	17,328	3,572	4.7%	26.0%
Wilson	6,259	7,759	1,500	4.4%	24.0%
Subtotal SSA	**89,344**	**108,141**	**18,797**	**3.9%**	**21.0%**
Total Service Area	**165,248**	**196,704**	**31,456**	**3.5%**	**19.0%**
Nashville MSA	143,298	171,218	27,920	3.6%	19.5%
Tennessee	411,603	482,174	70,571	3.2%	17.1%
United States	49,768,393	55,312,697	5,544,304	2.1%	11.1%

SOURCE: CLARITAS, INC.

The service area counties as a whole have a Median Household Income comparable to that of the Nashville MSA and United States, and higher than the state of Tennessee. The annual growth in median household income in the service area is again comparable to that of the state and lower than the MSA and U.S. overall—1.8% versus 2.0%, 2.6%, and 2.8% respectively. Please see **EXHIBIT 7.**

EXHIBIT 7
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income	
	2013	2018
Primary Service Area		
Davidson	$40,754	$37,987
Subtotal PSA	**$40,754**	**$37,987**
Secondary Service Area		
Cheatham	$48,200	$45,659
Dickson	$37,394	$33,257
Hickman	$43,174	$45,611
Humphreys	$36,403	$34,085
Maury	$43,414	$42,808
Montgomery	$47,374	$49,381
Robertson	$50,102	$49,715
Rutherford	$47,640	$44,297
Sumner	$44,938	$40,602
Williamson	$83,220	$85,190
Wilson	$51,271	$47,328
Subtotal SSA	**$48,466**	**$47,085**
Total Service Area	**$47,824**	**$46,327**
Nashville MSA	$45,778	$43,270
Tennessee	$40,760	$40,157
United States	$49,297	$49,815

SOURCE: CLARITAS, INC.

In terms of the TennCare population, 14.7% of the service area population is enrolled compared to 18.5% for the state overall. Please see **Attachment C, Need – 4 (Tab 11)**.

As a member of Ascension Health, the nation's largest Catholic healthcare system, Baptist Hospital continues to build and strengthen sustainable collaborative efforts that benefit the health of individuals, families, and society as a whole. The goal of Baptist Hospital is to perpetuate the healing mission of the church. Baptist Hospital furthers this goal through delivery of patient services, care to the elderly, indigent, and impoverished persons/families, patient education and health awareness programs for the community, and medical research. Our concern for the human life and dignity of all persons leads the organization to provide medical services to all people in the community without regard to the patient's race, creed, national origin, economic status, or ability to pay.

Baptist collaborates with many community organizations to improve the community health and expand access to health care including support for the Faith Family Clinic, an independent faith-based clinic for the poor located on the hospital campus at no cost to the clinic. In addition, Baptist continues to be active in networking with other healthcare providers in the Nashville area as part of the Bridges to Care (BTC) program, which links uninsured residents of Nashville to a network of some 35 safety net primary care, dental, mental health, and substance abuse clinics

that serve patients based on their ability to pay. The Baptist UT (University of Tennessee) Resident Clinic housed on the Baptist campus is a BTC referral clinic. BTC also provides help with prescription medications and transportation. In the last year, the hospital's Health Ministry has encouraged physician participation in the Bridges to Care program. This program, administered by the Nashville Academy of Medicine, links BTC participants to physician specialists upon referral by their primary care physician. Baptist Hospital provides the appropriate inpatient care services as a participant of this program.

Baptist Hospital also participates in a program developed by Saint Thomas Health to assist in the provision of vital medications to those challenged by poverty called the Dispensary of Hope Program. This program started from a network of physician offices donating sample medications and has evolved to obtaining huge donations of medications from pharmaceutical companies and wholesale distributors. The expansion of the Dispensary as a region-wide program now allows broader and cost effective distribution of medications to persons who are poor through a collaborative network of pharmacies at existing healthcare providers. Medications are shared with safety net clinic sites and the Bridges to Care program, as well as with many of the transplant patients of the hospital who would otherwise not be able to afford costly pharmaceutical post-transplant care. The Dispensary has recently added a 90 day mail supply capability, which greatly expands its ability to respond to those in need.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: No new services or equipment are proposed. Baptist Hospital is only proposing to consolidate and expand its orthopedic operating rooms into an orthopedic surgery suite that will be located on the eighth floor of the hospital. Within Baptist Hospital's 12-county primary and secondary service area, 23 hospitals provide surgical services.

Of these 23 facilities, Baptist, and six other providers in Davidson County complete the majority of the service area's major orthopedic surgeries[1]. Please see **Exhibit 8** below which details historical surgical volumes at these seven hospitals. Over the past three years, Baptist Hospital has been one of the top three Nashville hospitals in terms of total surgical volume as measured by both encounters and procedures. In addition, Baptist Hospital has been one of the most highly utilization surgical services in the Nashville area, averaging 607 encounters and 1,328 procedures per operating room in 2011. Please see **Exhibits 8 and 9**.

[1] Including DRGs 470, 480, 481, and 482.

Exhibit 8
Top Service Area Orthopedic Surgery Providers
Surgical Trends, Total Surgeries, 2009 – 2011

	Inpatient								
	2009			2010			2011		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	26	9,008	24,852	26	6,253	21,268	26	9,387	22,875
Centennial Med Ctr	33	8,690	12,733	33	7,131	9,939	37	7,377	10,964
Saint Thomas Hospital	18	7,857	24,554	18	7,624	27,175	18	7,662	25,978
Skyline Med Ctr	12	2,393	0	12	2,266	0	12	2,113	2,141
Southern Hills Med Ctr	10	1,148	1,408	10	969	1,246	12	2,455	2,611
Summit Med Ctr	10	1,962	2,138	0	1,988	2,195	12	2,455	2,611
Vanderbilt Uni Hosp	54	21,283	40,462	61	21,633	43,346	62	22,242	46,436
	Outpatient								
	2009			2010			2011		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	0	8,054	14,023	0	8,291	15,129	2	7,601	14,319
Centennial Med Ctr	4	11,571	17,845	4	3,858	4,566	0	10,817	16,456
Saint Thomas Hospital	2	2,885	5,360	2	3,084	5,852	2	3,580	6,574
Skyline Med Ctr	0	3,081	0	0	2,906	0	0	2,769	2,748
Southern Hills Med Ctr	10	2,662	4,318	10	2,344	4,692	0	2,932	3,525
Summit Med Ctr	0	3,797	4,299	0	3,515	4,167	0	2,932	3,525
Vanderbilt Uni Hosp	3	18,597	30,627	6	23,674	39,399	5	25,631	43,705

Source: Tennessee Joint Annual Reports, 2009 - 2011

Exhibit 9
Inpatient and Outpatient Surgical Utilization per Operating Room
Surgical Trends, Total Surgeries, 2009 – 2011

	Inpatient and Outpatient Utilization per OR								
	2009			2010			2011		
Facility	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR
Baptist Hospital	26	656	1,495	26	559	1,400	28	607	1,328
Centennial Med Ctr	37	548	826	37	297	392	37	492	741
Saint Thomas Hospital	20	537	1,496	20	535	1,651	20	562	1,628
Skyline Med Ctr	12	456	0	12	431	0	12	407	407
Southern Hills Med Ctr	20	191	286	20	166	297	12	449	511
Summit Med Ctr	10	576	644	0	N/A	N/A	12	449	511
Vanderbilt Uni Hosp	57	700	1,247	67	676	1,235	67	715	1,345

Source: Tennessee Joint Annual Reports, 2009 - 2011

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE: Baptist Hospital provides a wide range of surgical services, including orthopedic surgery services, and it will continue to do so in the future. Today, Baptist Hospital operates 26 inpatient operating rooms and two outpatient operating rooms. Over the past five years (2008 to 2012), the hospital has accounted for, on average, almost 16,500 surgical encounters.

Baptist Hospital's orthopedic surgery program is a comprehensive service line that has received regional recognition for its quality and overall excellence. Its orthopedic program is ranked number one in Tennessee and among the top five for orthopedics nationally. Baptist Hospital is currently the provider of choice for the Tennessee Titans football team. The service line includes services for the foot and ankle, joint replacement, sports medicine, hand and upper extremity, general orthopedics, spine, and rehabilitation. From 2008 to 2012, Baptist Hospital's orthopedic surgery program accounted for over 2,800 patient encounters annually.

Baptist Hospital's joint replacement program is especially strong, led by a team of joint replacement specialists including surgeons, orthopedic certified nurses, patient care technicians, case managers and physical therapists. Baptist Hospital performs almost 1,450 joint replacements annually, which account for approximately 50% of its total orthopedic surgery volume. The hospital's orthopedic surgeons have historically been leaders and innovators in joint replacement, having developed some of the first implants and surgical protocols. In addition, Baptist Hospital orthopedic surgeons have been active participants in research programs and the design of new technology for joint replacement. Joint replacement services include procedures for shoulder replacements, hip replacements and knee replacements. Baptist Hospital also provides free public seminars on a range of topics related to joint pain. In addition, the hospital's orthopedic surgery program performs surgeries on between 400 and 500 fracture cases annually. Please see the following exhibit profiling Baptist Hospital's surgical volumes over the past five years.

EXHIBIT 10
BAPTIST HOSPITAL SURGICAL TRENDS AND UTILIZATION, 2008 - 2012

	2008	2009	2010	2011	2012	Average
Total Surgery	17,444	17,062	14,544	16,988	16,415	16,491
Orthopedic Surgery	2,846	3,024	2,809	2,714	2,738	2,826
Joint Replacement Surgery	1,421	1,485	1,436	1,419	1,402	1,433
Fracture Surgery	496	513	458	415	435	463

Source: Baptist Hospital

The intent of the project is to consolidate and expand four orthopedic operating rooms that the hospital uses primarily for joint replacement and fracture surgery, which are located in multiple locations in the hospital. Baptist Hospital will consolidate these four existing orthopedic operating rooms in an orthopedic surgical suite with dedicated PACU and Prep/Recovery. In addition, inpatient orthopedic surgical patients will be cared for on an adjacent inpatient unit, furthering Baptist Hospital's goal of improving patient flow and care coordination by creating a "single floor" experience. Baptist Hospital expects that it will achieve operational efficiencies and quality enhancements from this project.

Because of recent trends of flat and some decline in joint replacement volumes, Baptist Hospital conservatively projects that it will perform 1,417 joint replacement and fracture surgical cases in its

eighth floor orthopedic surgery suite in Year 1 (FY2015) and 1,487 surgical cases in Year 2 (FY2016).

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
   - The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. NOTE: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

   RESPONSE: The CON filing fee is calculated at a rate of $2.25 per $1,000 of project costs as reported on Line D.

   No leases are involved with this project.

   Moveable equipment in Line A.8 includes various orthopedic surgery instruments, a C-arm, a Hanna table, a fracture table, anesthesia machines and a SPD washer.

   No maintenance agreements are included in the project.

   Please see **Attachment C, Economic Feasibility – 1 (Tab 12)** for a letter supporting the construction costs.

PROJECT COSTS CHART

2013 JUL 15 AM 10 07

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	$473,578
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$30,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs	$6,054,931
6.	Contingency Fund (Owner's Contingency)	$193,903
7.	Fixed Equipment (Not included in Construction Contract)	$2,145,000
8.	Moveable Equipment (List all equipment over $50,000)	$1,554,632
9.	Other (Clinical informatics, etc)	$1,021,636

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	

C. Financing Costs and Fees:

1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	

D. Estimated Project Cost (A+B+C)	$11,473,680
E. CON Filing Fee	$25,816
F. Total Estimated Project Cost (D+E)	$11,499,496

TOTAL $11,499,496

2. Identify the funding sources for this project.
Please check the applicable item(s) below and briefly summarize how the project will be financed. 2013 JUL 19 PM 12:07
(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

___ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

___ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants--Notification of intent form for grant application or notice of grant award; or

__X__ E. Cash Reserves **(Tab 13)**

___ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: At an average renovation cost of $339.36 per square foot, including demolition and construction contingency ($303.21, not including demolition) the costs for this project are comparable to other recently approved Tennessee CON projects. Baptist Hospital's renovation costs will be higher than the median costs because of the higher construction costs involved with surgical facilities and because the renovation is occurring on an existing patient floor as opposed to an existing surgical suite, which requires added mechanical requirements. **Exhibit 11**, below, lists the average hospital construction cost per square foot for all CON-approved applications for years 2010 through 2012.

EXHIBIT 11
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
APPROVED PROJECTS, 2010 - 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: Tennessee HSDA

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution.

Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

RESPONSE: Please refer to the completed charts on pages 31 through 34.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

RESPONSE: Based on Year 2 projections (FY2016), the average gross patient charge per orthopedic procedure is $62,828. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 68.9%, resulting in an average net revenue per procedure of approximately $19,555.

HISTORICAL DATA CHART

2013 JUL 15 AM 10 07

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Numbers reported in thousands)

		Year 2011	Year 2012	Year 2013
A.	Utilization Data (Patient Days)	113,135	112,163	108,732
B.	Revenue from Services to Patients			
1.	Inpatient Services	$690,544	$780,339	$862,034
2.	Outpatient Services	371,468	408,992	399,432
3.	Emergency Services	64,527	71,046	69,385
4.	Other Operating Revenue (Specify) - Misc.	15,775	29,405	27,821
	Gross Operating Revenue	$1,142,315	$1,289,782	$1,358,672
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$715,893	$806,267	$883,666
2.	Provision for Charity Care	24,972	53,683	36,117
3.	Provisions for Bad Debt	14,368	9,962	21,308
	Total Deductions	$755,234	$869,913	$941,090
NET OPERATING REVENUE		$387,081	$419,869	$417,582
D.	Operating Expenses			
1.	Salaries and Wages	$135,028	$133,380	$127,496
2.	Physician's Salaries and Wages	0	0	0
3.	Supplies	68,938	74,598	77,106
4.	Taxes	0	0	0
5.	Depreciation	17,371	16,425	16,627
6.	Rent	0	0	0

7. Interest, other than Capital	9,899	9,195	8,524
8. Other Expenses (Specify) - Lab, Pharmacy, Other	135,304	152,984	150,771
Total Operating Expenses	$366,539	$386,582	$380,524
E. Other Revenue (Expenses) - Net (Specify)	$285	$0	$0
NET OPERATING INCOME (LOSS)	$20,827	$33,286	$37,058
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$20,827	$33,286	$37,058

PROJECTED DATA CHART

2013 JUL 10 AM 10 07

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in July. (Numbers reported in thousands)

		Year 2015	Year 2016
A.	Utilization Data (Patient Days)	106,291	105,228
B.	Revenue from Services to Patients		
1.	Inpatient Services	$956,317	$1,026,480
2.	Outpatient Services	449,483	477,448
3.	Emergency Services	78,079	82,937
4.	Other Operating Revenue (Specify)	24,408	24,089
	Gross Operating Revenue	$1,508,287	$1,610,954
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$1,006,066	$1,091,858
2.	Provision for Charity Care	38,611	41,291
3.	Provisions for Bad Debt	28,339	30,306
	Total Deductions	$1,073,016	$1,163,455
NET OPERATING REVENUE		$435,271	$447,499
D.	Operating Expenses		
1.	Salaries and Wages	$139,666	$145,534
2.	Physician's Salaries and Wages	0	0
3.	Supplies	74,711	76,538
4.	Taxes	0	0
5.	Depreciation	18,071	18,288
6.	Rent	0	0

7. Interest, other than Capital	9,539	9,367
8. Other Expenses (Specify: Lab, Pharmacy, Other)	160,310	163,579
Total Operating Expenses	$402,297	$413,306
E. Other Revenue (Expenses) – Net (Specify)	$0	$0
NET OPERATING INCOME (LOSS)	$32,974	$34,193
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$32,974	$34,193

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: Baptist Hospital presents the current and projected charges for an orthopedic surgery case in **Exhibit 12**. An annual increase of 5% between FY2013 and Year 1 of the project, FY2015, is projected. Afterwards, the hospital assumes that charges will increase by 5% annually. Despite the modest charge increase, Baptist Hospital expects that contractual and other adjustments will increase, which will result in lower net revenue per case. Baptist Hospital's project will improve operational efficiency and the overall level of orthopedic surgery care that it provides while maintaining a charge structure that is reasonable and reflects the complexity of its cases and the overall market for orthopedic surgery. As demonstrated in **Exhibit 13**, Baptist Hospital's orthopedic surgery charges compare favorably with other providers in Nashville.

EXHIBIT 12
BAPTIST HOSPITAL ORTHOPEDIC SURGERY
AVERAGE GROSS CHARGE PER CASE, CURRENT AND PROJECTED

	Current	FY2015	FY2016
Gross Charge	$54,273	$59,836	$62,828
Adjustment	$34,119	$40,083	$43,273
Net Revenue	$20,154	$19,753	$19,555

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: Comparison charge data for orthopedic surgery is very limited. To compare its orthopedic surgery charges with similar facilities, Baptist Hospital used Medicare data from the American Hospital Directory (AHD) or ahd.com, as a source. Baptist Hospital profiled eight Nashville hospitals from the AHD database. The number of Medicare orthopedic surgery inpatients ranged from a low of 18 patients for Nashville General Hospital at Meharry to a high of 1,472 patients for Saint Thomas Hospital. Because of the very low volume of orthopedic surgery patients reported by Nashville General Hospital at Meharry, Baptist Hospital excluded it from the comparison.

On average, the remaining seven hospitals averaged 737 orthopedic surgery inpatients and charged, on average, $64,323 per inpatient case. Average charges per case ranged from a low of $39,240 for Baptist Hospital Tower Surgical Hospital to a high of $92,828 for TriStar Skyline Medical Center. Baptist Hospital's average charge was $62,027, slightly less than the average for the seven hospitals. Three of the hospitals had charges higher than Baptist Hospital (TriStar Centennial, TriStar Skyline Medical Center and Vanderbilt University Medical Center) and three of the hospitals had lower charges than Baptist Hospital (Baptist North Tower Surgical Hospital, Saint Thomas Hospital and TriStar Southern Hills Medical Center).

Adjusting the average charge by the orthopedic surgery Medicare Case Mix Index (CMI) resulted in a range of "CMI adjusted" charges of $14,859 to $31,348 with an average CMI adjusted charge of $23,695. Baptist Hospital's CMI adjusted charge was $22,694, again, slightly less than the average for the seven hospitals. Please see **Exhibit 13**, which profiles the orthopedic surgery average charge data for the Nashville hospitals.

EXHIBIT 13
NASHVILLE AREA HOSPITALS
AVERAGE GROSS CHARGE PER MEDICARE ORTHOPEDIC SURGERY CASE

Hospital	Inpatients	Avg Charges	CMI	CMI Adj Charge
Baptist Hospital	903	$62,027	2.7332	$22,694
Baptist North Tower Surgical Hospital	365	$39,240	2.6408	$14,859
Saint Thomas Hospital	1,472	$52,512	2.4128	$21,764
TriStar Centennial	1,030	$76,897	3.1111	$24,717
TriStar Skyline Medical Center	331	$92,828	2.9612	$31,348
TriStar Southern Hills Medical Center	131	$51,117	2.5241	$20,252
Vanderbilt University Medical Center	926	$75,637	2.5020	$30,231
Average	**737**	**$64,323**	**2.6979**	**$23,695**

Source: American Hospital Directory, ahd.com

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: Baptist Hospital's orthopedic surgery service line is already financially feasible. This proposal will enhance the current service line by consolidating and expanding its operating rooms into an orthopedic surgery suite. The proposed project will improve operational efficiency including patient flow and staff productivity by operating the orthopedic service line in one location and providing a single floor experience for the patient. In addition, expanding the size of the operating rooms will allow Baptist Hospital to providing imaging equipment and larger operating tables in the operating rooms, which will allow its physicians to perform more cases that are complex. Baptist Hospital and area payors will benefit from an increase in projected utilization rates and cost-effectiveness. As indicated in the Projected Data Chart, projected utilization will be sufficient to continue to allow Baptist Hospital to operate efficiently and effectively.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

RESPONSE: As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within two years and over the long-term.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: Baptist Hospital currently participates in both the Medicare and TennCare/Medicaid programs and has a history of providing care regardless of payor source. Using 2012 Joint Annual Report data, Baptist Hospital had an estimated payor mix (based on gross charges) that was 37.9% Medicare, 12.5% Medicaid/TennCare and 4.8% self pay. Additionally, based on the 2012 JAR, Baptist provided $53,215,189 in care to charity/medically indigent patients (accounting for 13.7% of net patient charges of $389,421,191). During the first year of operation, Baptist Hospital's payor mix is anticipated to be 37.9% Medicare and 14.0% Medicaid/TennCare. This amounts to approximately $562,390,141 in Medicare gross charges in Year 1 and $207,743,060 Medicaid/TennCare gross charges in Year 1. In addition, Baptist Hospital proposes to provide $38,611,000 in charity care in Year 1.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

RESPONSE: Please see **Attachment C, Economic Feasibility – 10 (Tabs 14 and 15)**.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

RESPONSE: Baptist Hospital anticipates improved operational efficiencies, larger operating rooms with the capability to perform complex surgical procedures and quality enhancements after implementing its proposal to consolidate and expand four of its orthopedic operating rooms. These specific goals are consistent with Baptist Hospital's overall goals. As discussed, the existing orthopedic operating rooms are not centrally located and are undersized and unable to accommodate the imaging equipment and larger operating tables needed for complex orthopedic cases. As with most medical/surgical hospitals, orthopedic surgery is a key service line for Baptist Hospital and one of the core services that it offers. The current arrangement of orthopedic operating rooms limits the types of procedures that the hospital's surgeons can perform, creates poor patient flows, limits staff productivity and creates physician dissatisfaction with the service line's facilities.

Although studied, Baptist Hospital did not consider renovating and enlarging the existing operating rooms in their current locations to be a viable option. First, renovation of the existing operating rooms would require Baptist Hospital to interrupt operations of these rooms, which would limit the hospital's surgical capacity and disrupt services. To accommodate the expansion of its orthopedic operating rooms, Baptist Hospital would have to expand into areas adjacent to the existing operating rooms, which was not desirable. In addition, enlarging the existing operating rooms would not address the operational issues that currently exist by not having the four orthopedic operating rooms located in the same area.

Although new construction of an orthopedic surgery suite was an option, Baptist Hospital considered the proposed project to be a superior plan. Baptist Hospital anticipated the cost of new construction to be higher than the costs of the proposed project. In addition, new construction would not allow the orthopedic surgery suite to be contiguous to an inpatient unit thereby allowing Baptist Hospital to create a single floor experience for its orthopedic patients and gain the advantage of improved staff communication and care coordination that comes from the surgical suite and inpatient unit being on the same floor and contiguous.

Baptist Hospital's proposal to renovate the eighth floor to accommodate an orthopedic surgery suit is the most responsible plan for addressing the current facility limitations of the orthopedic surgical service. The project addresses all of the deficiencies of Baptist Hospital's existing orthopedic operating rooms and does so in a cost-effective approach.

b. The applicant should document that consideration has been given to alternatives to new

construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: Not applicable. This project does not involve any new construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

RESPONSE: As a member of Saint Thomas Health, Baptist Hospital is a member of an integrated healthcare system of four hospitals. Additionally, Baptist Hospital has many active relationship and several formal agreements in place to provide for seamless care of its patients, including:

Managed Care Contracts

- Aetna / US Healthcare
- Aetna Institutes of Quality Bariatric Surgery Facility
- Aetna Institutes of Quality Orthopedic Care
- Alive Hospice
- Americhoice
- AMERIGROUP Community Care
- Avalon Hospice
- Beech
- BC/BS of TN
- CCN
- Blue Distinction Center for Bariatric Surgery
- Blue Distinction Center for Knee and Hip Replacement
- Blue Distinction Center for Spine Surgery
- Bluegrass Family Health
- CenterCare Managed Care Programs
- Cigna Healthplan
- CorVel Corporation
- Coventry Health Care
- Division of Rehabilitation Services
- First Health
- FOCUS Healthcare Management
- Great West
- HealthMarkets Care Assured
- Health Payors Organization, Ltd. / Interplan Healthgroup
- HealthSpring
- Humana Health Care Plans
- KY Medicaid
- MultiPlan
- NovaNet
- OccuComp
- Odyssey Healthcare
- Prime Health
- Private Healthcare Systems, Ltd.
- Pyramid Life - Today's Options
- Signature Health Alliance
- Southern Benefit Administrators, Inc.
- Starbridge Choice
- Sterling Healthcare

- TriCare for Life
- TRICARE North
- TRICARE South
- United Healthcare
- USA Managed Care Organization
- Windsor HealthCare

Transfer Agreements

- American Endoscopy Center, P.C.
- Baptist Plaza Surgicare, LP (USPI)
- Baptist Women's Health Center, LLC d/b/a The Center for Spinal Surgery (USPI)
- Biomat USA, Inc.
- Blakeford at Green Hills d/b/a Woodcrest Healthcare Center
- Clarksville Health System, G.P.
- Cool Springs Surgery Center
- Crockett Hospital, LLC
- Cumberland Medical Center, Inc.
- Decatur County General Hospital
- Decatur County General Hospital
- Digestive Disease Endoscopy Center, Inc
- Emergency Patient Transfer - Mutual Agreement for Emergency Patient Transfer
- Eye Surgery Center of Nashville
- Hardin Medical Center
- Joseph B. Delozier, III, PLLC - Baptist
- Lincoln Medical Center
- Lincoln Medical Center - Baptist
- Livingston Regional Hospital, LLC
- Maxwell Aesthetics, PLLC - Baptist
- Nashville Vision Correction - Baptist
- Office of Emergency Management
- Oral Facial Surgery Center, Inc.
- Pinelake Regional Hospital, LLC d/b/a Jackson Purchase Medical Center
- Renal Care Group, Inc
- Saint Thomas Hospital
- Southern Tennessee Medical Center
- Specialty MRI (Radiology Alliance)
- Tullahoma HMA, LLC d/b/a Harton Regional Medical Center
- Urology Surgery Center, L.P.
- Vanderbilt University
- Vanderbilt University - Burn Patient
- Vanderbilt University - Organ Transplant and Intensive Care Pediatrics
- Wellmont Bristol Regional Medical Center

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

RESPONSE: Baptist Hospital's proposal will have a positive impact on the health care system. It enhances the orthopedic services that the hospital currently provides by improving operational efficiency, expanding the capabilities of the hospital to perform complex orthopedic procedures

and, in general, offer a higher quality of orthopedic service. Baptist Hospital anticipates that the project will have little, if any, impact on service duplication because Baptist Hospital currently offers orthopedic surgery services and will not add any more operating rooms. At the completion of the project, Baptist Hospital will operate 28 operating rooms, which is the number that it currently operates.

The project will bring Baptist Hospital's orthopedic surgery facilities up to current standards and will make the service line more competitive with area hospitals that have modern surgical facilities. Baptist Hospital anticipates that the successful completion of the project will increase utilization of its orthopedic surgery service. Baptist Hospital expects its enhanced competitiveness will have a positive impact on the health care system, the health care payor, the health care consumer and the physician.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

RESPONSE: In anticipation of increased utilization, Baptist Hospital has budgeted approximately 5.7 additional FTEs for the proposed project. Baptist Hospital has a history of successfully retaining professional and administrative staff because it provides competitive benefits and compensation, and provides a supportive work environment. As mentioned previously, in recent years, Baptist Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

EXHIBIT 14 illustrates current and proposed staffing levels of the proposed project. Baptist Hospital will add approximately 5.7 FTEs to staff the proposed project.

EXHIBIT 14
CURRENT AND PROPOSED STAFFING LEVELS
ORTHOPEDIC SURGERY
(FULL TIME EQUIVALENTS)

Position	Current	Proposed	Difference
Administrative	2.0	2.0	0.0
Registered Nurses	6.4	8.7	2.3
Surgical Technicians	9.6	13.0	3.4
Total	**18.0**	**23.7**	**5.7**

EXHIBIT 15 profiles comparable positions and salaries for the Nashville-Davidson-Murfreesboro MSA. Baptist Hospital's salaries and wages are competitive with the market. The proposed project's average proposed annual salary for registered nurses is $68,081 while the average salary for surgical technicians is $58,205. These midpoint values very competitive compared to the Nashville-Davidson-Murfreesboro MSA.

EXHIBIT 15
NASHVILLE-DAVIDSON-MURFREESBORO MSA
MAY 2012 ANNUAL WAGE RATES

Position	25th Pctile	Mean	Median	75th Pctile
Registered Nurses	$48,220	$58,260	$58,060	$68,600
Surgical Technicians	$34,290	$42,090	$39,970	$49,100

SOURCE: ANNUAL SALARY BLS OCCUPATIONAL EMPLOYMENT STATISTICS SURVEY DATA

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

RESPONSE: Baptist Hospital proposes adding just 5.7 additional FTEs. Baptist Hospital has a history of successfully recruiting professional and administrative staff. It provides competitive benefits and compensation, and is committed to the retention of existing personnel. In recent years, Baptist Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

RESPONSE: Baptist Hospital has reviewed and understands the licensure and certification requirements for medical and clinical staff. As an existing licensed and Joint Commission-accredited facility, Baptist Hospital has administrative policies and procedures in place to ensure that licensure and certification requirements are followed. Furthermore, Baptist Hospital maintains quality standards that are focused on continual improvement. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 5** for copies of its Quality and Patient Safety Improvement Plan **(Tab 17)**, and Utilization Review Plan **(Tab 18)** and Patient Bill of Rights **(Tab 19)**.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

RESPONSE: Baptist Hospital participates in many regional healthcare teaching and training programs including:

- Aquinas College - Nursing Program
- Aquinas College - RN-BSN Program
- Auburn University – Nursing
- Austin Peay State University - Exercise Science Students
- Austin Peay State University - Medical Technology
- Austin Peay State University – Nursing
- Belmont University - Nursing Program
- Belmont University – Pharmacy
- Belmont University - Physical and Occupational Therapy (PT, OT)
- Central Michigan University - Exercise Science Program
- Chattanooga State Technical Community College - Diagnostic Medical Sonography, Radiation Therapy and Nuclear Medicine

- Columbia State Community College - Respiratory Care, EMS Education & Nursing
- Creighton University – Nursing
- Cumberland University - Nursing Program
- Draughons Junior College - Physical Therapy, Assistant Cardiographic and Medical Assistant
- Draughons Junior College, Inc d/b/a Daymar Institute - Pharmacy Technology
- Dyersburg State Community College - Health Information Technology
- Hospital Authority of Metropolitan Government of Nashville & Davidson County d/b/a Nashville General Hospital - Radiologic Technology
- Johns Hopkins University School of Nursing
- Lipscomb University - Dietetic Internship Program
- Lipscomb University - Exercise Science
- Lipscomb University College of Pharmacy - Pharmacy Students
- Lipscomb University Department of Nursing
- Madisonville Community College - Medical Equipment and Instrumentation Students
- Medvance Institute - Medical Laboratory Technician
- Medvance Institute - Surgical Technology and Sterile Technology Programs
- Middle Tennessee State University (MTSU) - Exercise Science
- Middle Tennessee State University (MTSU) - Medical Nutrition Therapy Dietetic Practicum
- Middle Tennessee State University (MTSU) - Nursing program
- Middle Tennessee State University (MTSU) - Social Work
- Miller-Motte Technical College - Respiratory Therapy, Surgical Technology and Sterile Processing
- Motlow State Community College – Nursing
- Mountain State University - Radiology Students
- Murray State University – Nursing
- Nashville State Community College - Nursing - Surgical Technician Program - Surgical Assist Program
- Nashville State Technical Community College - Occupational Therapy Program
- Pennsylvania State University - Nursing Program
- Samford University - Nursing (Graduate Nursing Clinical Experience Management, Nurse Executive and Nurse Educator Students)
- South Carolina College of Pharmacy - Doctor of Pharmacy
- Southeastern Institute - Paramedic Students
- Southern Adventist University – Nursing
- St. Louis University, School of Nursing
- Tennessee Board of Regents (TBR) - Master of Science in Nursing Regents Online Degree Program (APSU, ETSU, MTSU, TSU, TTU, and Memphis)
- Tennessee State University (TSU) - Health Exercise Science (Baptist Sports Medicine)
- Tennessee State University (TSU) – Nursing
- Tennessee State University (TSU) - Physical, Occupational Therapy, Health Information Management and Cardio-Respiratory Care
- Tennessee Technological University - Nursing and Dietetics Program
- Tennessee Technology Center at Murfreesboro - Pharmacy Technician, Phlebotomy, and Surgical Tech
- Tennessee Technology Center at Nashville - LPN, Phlebotomy & Pharmacy Tech
- Tennessee Technology Center at Shelbyville and Murfreesboro Campuses - Practical Nursing Program
- Trevecca Nazarene University - Social Work Students
- University of Alabama, Huntsville – Nursing
- University of Alabama, Tuscaloosa – Nursing
- University of Florida - Pham. D. Program
- University of St. Francis - Nursing Students

- University of Tennessee (Memphis) - Physical Therapy, Occupational Therapy, Medical Technology, Cytotechnology and Histotechnology
- University of Tennessee at Chattanooga - Physical Therapy
- University of Tennessee at Martin - Clinical Nutrition and Food Service Management
- University of Tennessee, Knoxville – Nursing
- University of Tennessee, Knoxville - Social Work
- University of Tennessee, Martin - Exercise Science
- University of Tennessee, Memphis - Pharmacy Program
- Vanderbilt School of Nursing – Nursing
- Vanderbilt University - Hearing and Speech Sciences
- Volunteer State Community College - Multi-Programs
- Walden University - MS Nursing Students)
- Western Kentucky University - Nursing Program

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

RESPONSE: As an existing hospital, Baptist Hospital is licensed by the Tennessee Department of Health. Baptist Hospital has reviewed and understands the licensure requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board of Licensing Health Care Facilities, State of Tennessee, Department of Health.

Accreditation: Baptist Hospital is accredited by The Joint Commission (on Accreditation of Healthcare Organizations). Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 20)** for the most recent report.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(c) (Tab 21).** The current license is valid until April 30, 2014.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(d)** for a copy of the most recent licensure/certification inspection report **(Tab 22)** and plan of corrective action **(Tab 23)**.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE: There have been no final orders or judgments placed against Baptist Hospital or any entity or person with more than 5 percent ownership.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

RESPONSE: There have been no civil or criminal judgments against Baptist Hospital or any entity or person with more than 5 percent ownership.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required.

RESPONSE: Yes, Baptist Hospital will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required. Additionally, Baptist Hospital submits a Joint Annual Report (JAR) to the Department of Health and will continue to do so.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see **Attachment D – Proof of Publication (Tabs 24-25).**

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   RESPONSE: The project completion schedule below reflects the anticipated schedule for the cardiac and medical imaging project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

2013 JUL 15 AM 10 08

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-160! October, 23 2013

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	0	Jul-13
2. Construction documents approved by the Tennessee Department of Health	60	Dec-13
3. Construction contract signed	30	Nov-13
4. Building permit secured	60	Dec-13
5. Site preparation completed	N/A	
6. Building construction commenced	60	Dec-13
7. Construction 40% complete	120	Feb-14
8. Construction 80% complete	180	Apr-14
9. Construction 100% complete (approved for occupancy)	240	Jun-14
10. *Issuance of license	240	Jun-14
11. *Initiation of service	240	Jun-14
12. Final Architectural Certification of Payment	270	Jul-14
13. Final Project Report Form (HF0055)	270	Jul-14

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

2013 JUL 15 AM 10 08

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

Barbara Houchin being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Barbara Houchin / Executive Director
SIGNATURE/TITLE

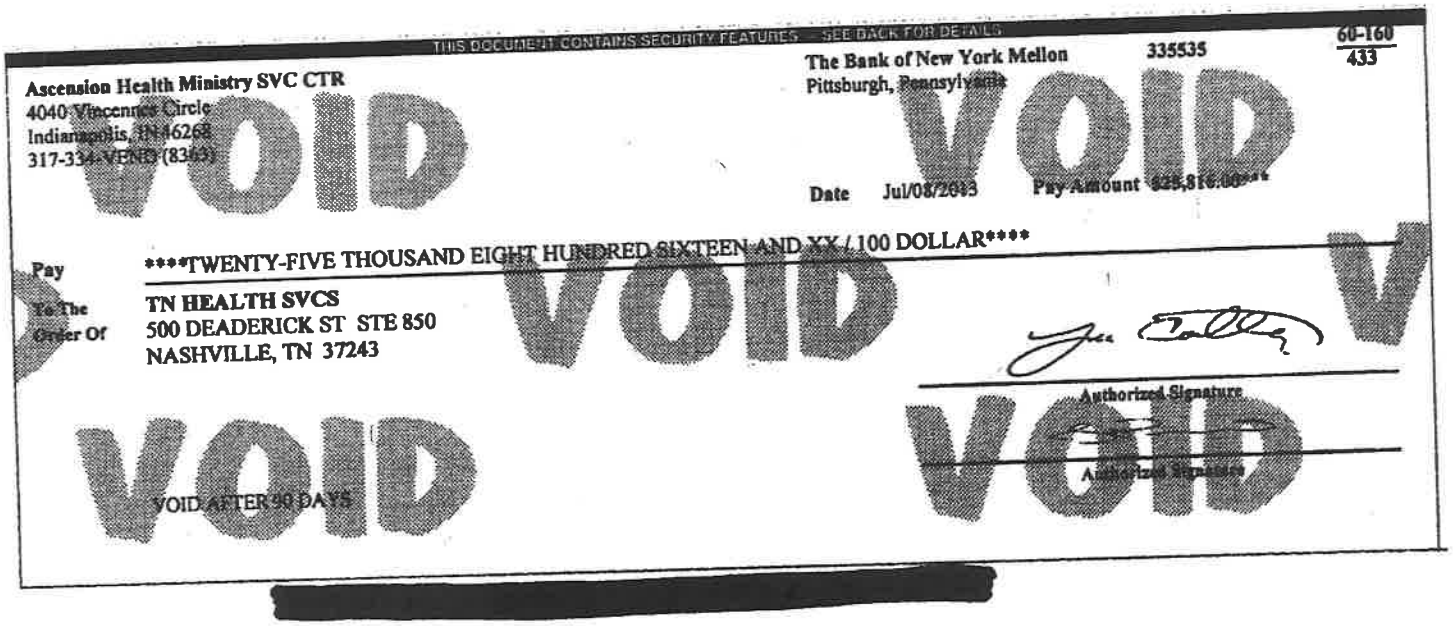
Sworn to and subscribed before me this 10th day of July (Month), 2013 (Year) a Notary

Public in and for the County/State of Davidson County, Tennessee

Lindsay Kate Owens
NOTARY PUBLIC

My commission expires 9/9 (Month/Day), 2014 (Year).

LINDSAY KATE OWENS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires September 9, 2014



THIS DOCUMENT CONTAINS SECURITY FEATURES - SEE BACK FOR DETAILS

Ascension Health Ministry SVC CTR
4040 Vincennes Circle
Indianapolis, IN 46268
317-334-VEND (8363)

The Bank of New York Mellon
Pittsburgh, Pennsylvania

335535

60-160
433

VOID VOID

Date Jul/08/2043 Pay Amount $25,816.00****

Pay ****TWENTY-FIVE THOUSAND EIGHT HUNDRED SIXTEEN AND XX/100 DOLLAR****

To The Order Of
TN HEALTH SVCS
500 DEADERICK ST STE 850
NASHVILLE, TN 37243

VOID VOID V

Authorized Signature

Authorized Signature

VOID AFTER 90 DAYS

VOID VOID

[redacted]

000052

TABLE OF CONTENTS

Attachment A

Corporate Charter
Organizational Chart
Board Roster
Certificate of Corporate Existence
Deed
MCO/BHO Participation

Tab 1

Attachment A, 3

Corporate Charter

cFinley

Secretary of State
Division of Business Services
312 Eighth Avenue North
Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 01/03/02
REQUEST NUMBER: 4378-2087
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 12/31/01 1516
EFFECTIVE DATE/TIME: 12/31/01 1630
CONTROL NUMBER: 0414306

TO:
BOULT CUMMINGS CONNERS & BERRY PLC
PO BOX 198062

NASHVILLE, TN 37219

Davidson County CHARTER
Recvd: 01/07/02 16:15 7pgs
Fees:8.00 Taxes:0.00
20020107-0002449

RE:
SETON CORPORATION
AMENDED AND RESTATED CHARTER

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED DOCUMENT WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE.

PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

FOR: AMENDED AND RESTATED CHARTER

ON DATE: 01/03/02

	FEES	
RECEIVED:	$40.00	$0.00
TOTAL PAYMENT RECEIVED:		$40.00

RECEIPT NUMBER: 00002977184
ACCOUNT NUMBER: 00000413

FROM:
BOULT, CUMMINGS, CONNERS & BERRY
P. O. BOX 198062

NASHVILLE, TN 37219-0000

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

000057

SS-4458

FILED

CERTIFICATE OF SETON CORPORATION CONCERNING ITS AMENDED AND RESTATED CHARTER

RECEIVED
STATE OF TENNESSEE
01 DEC 31 PM 3:16
RILEY DARNELL
SECRETARY OF STATE

Corporate Control No. 0414306

Pursuant to the provisions of Section 48-60-106(h) of the Tennessee Nonprofit Corporation Act, as amended, Seton Corporation (the "Corporation") certifies as follows:

I. The name of the Corporation as it appears of record is Seton Corporation.

II. The Amended and Restated Charter to which this Certificate is attached amends Articles I through VIII of the Corporation's Charter by substituting therefor Articles I through VIII of the Amended and Restated Charter.

III. The Amended and Restated Charter was duly adopted by unanimous written consent of the Board of Trustees of the Corporation dated as of December 31, 2001 and approved by action of the Chief Executive Officer of Saint Thomas Health Services, a Tennessee nonprofit corporation and the sole member of the Corporation ("STHS").

IV. The Corporation is not for profit.

V. Approval of the amendments to the Charter by some person or persons other than the Board of Trustees and the Chief Executive Officer of STHS is not required pursuant to Section 48-60-301 of the Tennessee Nonprofit Corporation Act, as amended.

VI. The Amended and Restated Charter shall be effective on the date of filing.

DATED as of the 31st day of December, 2001.

SETON CORPORATION

By: Thomas E. Beeman
Thomas E. Beeman
Chairman, Board of Trustees

AMENDED AND RESTATED CHARTER OF SETON CORPORATION

Pursuant to the provisions of Section 48-60-106 of the Tennessee Nonprofit Corporation Act, as amended (the "Act"), Seton Corporation, a Tennessee nonprofit corporation (the "Corporation") adopts the following Amended and Restated Charter:

ARTICLE I
NAME

1.1 The name of the Corporation is Seton Corporation.

ARTICLE II
TYPE

2.1 The Corporation is a public benefit corporation.

2.2 The Corporation is not for profit.

ARTICLE III
PURPOSE

3.1 The Corporation is organized exclusively for charitable, religious, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Code"), including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code. The Corporation's purposes shall be consistent with and supportive of the corporate purposes of Ascension Health, a Missouri nonprofit corporation, and the Corporation's purposes shall include the following:

3.1.1 Serve as an integral part of the Roman Catholic Church and carry out its mission in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.2 Further the philosophy and mission of Ascension Health of healing and service for the sick and poor, and promote, support and engage in any of the religious, charitable, scientific and educational ministries which are now, or may hereafter be established by Ascension Health, or co-sponsored by the Sponsors (as that term is generally understood within the Ascension Health system) and which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.3 Raise funds for any or all of the organizations described in this Article from the public and from all other sources available; receive and maintain such

funds and expend principal and income therefrom in support of or in furtherance of the charitable purposes of such organizations.

3.1.4 Acquire, own, use, lease as lessor or lessee, convey and otherwise deal in and with real and personal property and any interest therein, all in support of or in furtherance of the charitable purposes of organizations described in this Article.

3.1.5 Contract with other organizations (for profit and nonprofit), with individuals and with governmental agencies in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.6 Establish, develop, sponsor, promote and/or conduct educational programs, religious programs, scientific research, treatment facilities, rehabilitation centers, housing centers, management services, human service programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in this Article.

3.1.7 Own or operate facilities or own other assets for public use and welfare in furtherance of the charitable purposes of the organizations described in this Article.

3.1.8 Engage in any lawful activities within the purposes for which a corporation may be organized under the Tennessee Nonprofit Corporation Act (the "Act"), as it may be amended from time to time, which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.9 Serve as the controlling entity of Subsidiary Organizations (as that term is generally understood within the Ascension Health system) that conduct health related and other activities, and limit the powers, duties and responsibilities of the governing bodies of such Subsidiary Organizations, all in accordance with requirements as established by the Corporate Member (as defined in Article V).

3.1.10 Support institutions co-sponsored by the Sponsors, both within and without Tennessee, and cooperate with other Ascension Health institutions.

3.1.11 Promote cooperation and exchange of knowledge and experience among the various apostolates of the Sponsors within the health care mission.

3.1.12 Otherwise operate in support of or in furtherance of the charitable purposes of the organizations described in this Article, and do so exclusively for religious, charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Code and in the course of such operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other private persons unless allowed by Section 501(c)(3) of the Code and the Act except that the Corporation shall be authorized and empowered to pay

reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

(c) Notwithstanding any other provisions of the Corporation's governing documents, the Corporation shall not carry on any other activities not permitted to be carried on: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

3.1.13 Operate a hospital and other health care providers and services in furtherance of the charitable purposes described above.

ARTICLE IV
PERIOD OF EXISTENCE

4.1 The period during which the Corporation shall continue is perpetual.

ARTICLE V
MEMBERSHIP

5.1 Members. The Corporation shall have members.

5.2 Identity of Member. There shall be one (1) member of the Corporation who shall be known as the "Corporate Member," and such Corporate Member shall be St. Thomas Baptist Health Corporation, a Tennessee nonprofit corporation.

5.3 Transferability of Membership Interest. The Corporate Member's interest as a member in the Corporation may be transferred by the Corporate Member.

ARTICLE VI
REGISTERED OFFICE, AGENT, PRINCIPAL OFFICE, AND INCORPORATOR

6.1 Registered Office and Agent. The street address, zip code and county of the registered office of the Corporation is 4220 Harding Road, Nashville, Davidson County, Tennessee 37205, and the name of the Corporation's registered agent at such address is Sister Priscilla Grimes, D.C.

6.2 Principal Office. The address of the principal office of the Corporation is 2000 Church Street, Nashville, Davidson County, Tennessee 37236.

6.3 Incorporator. The name and address of the Corporation's incorporator is J. B. Hardcastle, Jr., 414 Union Street, Suite 1600, Nashville, Davidson County, Tennessee 37219.

ARTICLE VII
BOARD OF TRUSTEES; RESERVED POWERS

7.1 Powers and Responsibilities. The business, property, and affairs of the Corporation shall be managed and controlled by the Corporation's Board of Trustees ("Board of Trustees" or "Board") in accordance with the policies established by the Corporate Member or any successor entity. The Board of Trustees shall act as the board of directors of the Corporation as required by the Act.

7.2 Powers Reserved to Corporate Member. All action of the Corporation shall be by its Board of Trustees, subject to the following matters which require the approval of the Corporate Member:

7.2.1 Approve the mission and vision statements for the Corporation and assure compliance with the philosophy, mission, vision, Sponsor expectations and core values of the System.

7.2.2 Approve changes to the Governing Documents (as that term is generally understood within the Ascension Health system) of the Corporation and its non-controlled subsidiaries that are consistent with the System's Requirements for Governing Documents (as that term is generally understood within the Ascension Health system).

7.2.3 Approve changes to the Governing Documents of the Corporation and its non-controlled subsidiaries that are inconsistent with the System's Requirements for Governing Documents, provided that Ascension Health also approves such changes.

7.2.4 Appoint, upon the recommendation of the Board of the Corporation, or remove, with or without cause, the members of the Board of Trustees of the Corporation. Removal does not require a recommendation of the Corporation's Board.

7.2.5 Approve the incurrence of debt of the Corporation in accordance with the System Authority Matrix (as that term is generally understood within the Ascension Health system).

7.2.6 Subject to canonical requirements, approve and recommend the formation of legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, closures, mergers, consolidations, or changes in corporate membership of the Corporation in accordance with the System Authority Matrix.

7.2.7 Approve the transfer or encumbrance of the assets of the Corporation in accordance with the System Authority Matrix.

7.2.8 Approve the operating budget and capital plan for the Corporation.

7.2.9 Deviate from the polices and restrictions imposed on the Corporation by the Corporate Member.

ARTICLE VIII
DISSOLUTION

8.1 Upon the dissolution of the Corporation, the disposition of all the assets of the Corporation shall be in a manner as provided by the Board of Trustees (subject to the prior approval of the Corporate Member) and in accordance with the following:

8.1.1 The paying of or the making of provision of the payment of all of the liabilities, direct or indirect, contingent or otherwise, including without limitation, all liabilities evidenced in all outstanding loan agreements, credit agreements, master indentures and other similar documents.

8.1.2 Subject to compliance with the dissolution principles of the Corporate Member, all assets remaining after the payment of all of the liabilities of the Corporation shall be distributed, exclusively in furtherance of the religious, charitable, scientific, literary and educational purposes of the Corporation within the meaning of Section 501(c)(3) of the Code, to St. Thomas Baptist Health Corporation or such other exempt organization(s) under Section 501(c)(3) of the Code that is a Subsidiary Organization of St. Thomas Baptist Health Corporation, or to such other exempt organization(s) under Section 501(c)(3) of the Code as shall be determined by the Members of Ascension Health.

8.1.3 Any other assets not so disposed of shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

This Amended and Restated Charter shall be effective on December 31, 2001.

AMENDED AND RESTATED CHARTER OF SETON CORPORATION

Pursuant to the provisions of Section 48-60-106 of the Tennessee Nonprofit Corporation Act, as amended (the "Act"), Seton Corporation, a Tennessee nonprofit corporation (the "Corporation") adopts the following Amended and Restated Charter:

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1.1 The name of the Corporation is Seton Corporation.

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TYPE

2.1 The Corporation is a public benefit corporation.

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3.1.1 Serve as an integral part of the Roman Catholic Church and carry out its mission in support of or in furtherance of the charitable purposes of the organizations described in this Article.

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funds and expend principal and income therefrom in support of or in furtherance of the charitable purposes of such organizations.

3.1.4 Acquire, own, use, lease as lessor or lessee, convey and otherwise deal in and with real and personal property and any interest therein, all in support of or in furtherance of the charitable purposes of organizations described in this Article.

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3.1.8 Engage in any lawful activities within the purposes for which a corporation may be organized under the Tennessee Nonprofit Corporation Act (the "Act"), as it may be amended from time to time, which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

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3.1.12 Otherwise operate in support of or in furtherance of the charitable purposes of the organizations described in this Article, and do so exclusively for religious, charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Code and in the course of such operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other private persons unless allowed by Section 501(c)(3) of the Code and the Act except that the Corporation shall be authorized and empowered to pay

reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

(c) Notwithstanding any other provisions of the Corporation's governing documents, the Corporation shall not carry on any other activities not permitted to be carried on: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

3.1.13 Operate a hospital and other health care providers and services in furtherance of the charitable purposes described above.

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PERIOD OF EXISTENCE

4.1 The period during which the Corporation shall continue is perpetual.

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5.1 Members. The Corporation shall have members.

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ARTICLE VI
REGISTERED OFFICE, AGENT AND PRINCIPAL OFFICE

6.1 Registered Office and Agent. The street address, zip code and county of the registered office of the Corporation is 4220 Harding Road, Nashville, Davidson County, Tennessee 37205, and the name of the Corporation's registered agent at such address is Sister Priscilla Grimes, D.C.,

6.2 Principal Office. The address of the principal office of the Corporation is 2000 Church Street, Nashville, Davidson County, Tennessee 37236.

ARTICLE VII
BOARD OF TRUSTEES; RESERVED POWERS

7.1 Powers and Responsibilities. The business, property, and affairs of the Corporation shall be managed and controlled by the Corporation's Board of Trustees ("Board of Trustees" or "Board") in accordance with the policies established by the Corporate Member or any successor entity. The Board of Trustees shall act as the board of directors of the Corporation as required by the Act.

7.2 Powers Reserved to Corporate Member. All action of the Corporation shall be by its Board of Trustees, subject to the following matters which require the approval of the Corporate Member:

7.2.1 Approve the mission and vision statements for the Corporation and assure compliance with the philosophy, mission, vision, Sponsor expectations and core values of the System.

7.2.2 Approve changes to the Governing Documents (as that term is generally understood within the Ascension Health system) of the Corporation and its non-controlled subsidiaries that are consistent with the System's Requirements for Governing Documents (as that term is generally understood within the Ascension Health system).

7.2.3 Approve changes to the Governing Documents of the Corporation and its non-controlled subsidiaries that are inconsistent with the System's Requirements for Governing Documents, provided that Ascension Health also approves such changes.

7.2.4 Appoint, upon the recommendation of the Board of the Corporation, or remove, with or without cause, the members of the Board of Trustees of the Corporation. Removal does not require a recommendation of the Corporation's Board.

7.2.5 Approve the incurrence of debt of the Corporation in accordance with the System Authority Matrix (as that term is generally understood within the Ascension Health system).

7.2.6 Subject to canonical requirements, approve and recommend the formation of legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, closures, mergers, consolidations, or changes in corporate membership of the Corporation in accordance with the System Authority Matrix.

7.2.7 Approve the transfer or encumbrance of the assets of the Corporation in accordance with the System Authority Matrix.

7.2.8 Approve the operating budget and capital plan for the Corporation.

7.2.9 Deviate from the polices and restrictions imposed on the Corporation by the Corporate Member.

ARTICLE VIII
DISSOLUTION

8.1 Upon the dissolution of the Corporation, the disposition of all the assets of the Corporation shall be in a manner as provided by the Board of Trustees (subject to the prior approval of the Corporate Member) and in accordance with the following:

8.1.1 The paying of or the making of provision of the payment of all of the liabilities, direct or indirect, contingent or otherwise, including without limitation, all liabilities evidenced in all outstanding loan agreements, credit agreements, master indentures and other similar documents.

8.1.2 Subject to compliance with the dissolution principles of the Corporate Member, all assets remaining after the payment of all of the liabilities of the Corporation shall be distributed, exclusively in furtherance of the religious, charitable, scientific, literary and educational purposes of the Corporation within the meaning of Section 501(c)(3) of the Code, to St. Thomas Baptist Health Corporation or such other exempt organization(s) under Section 501(c)(3) of the Code that is a Subsidiary Organization of St. Thomas Baptist Health Corporation, or to such other exempt organization(s) under Section 501(c)(3) of the Code as shall be determined by the Members of Ascension Health.

8.1.3 Any other assets not so disposed of shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

This Amended and Restated Charter shall be effective on December 31, 2001.

SETON CORPORATION

By: Thomas E. Burns
President and Chief Executive Officer

Tab 2

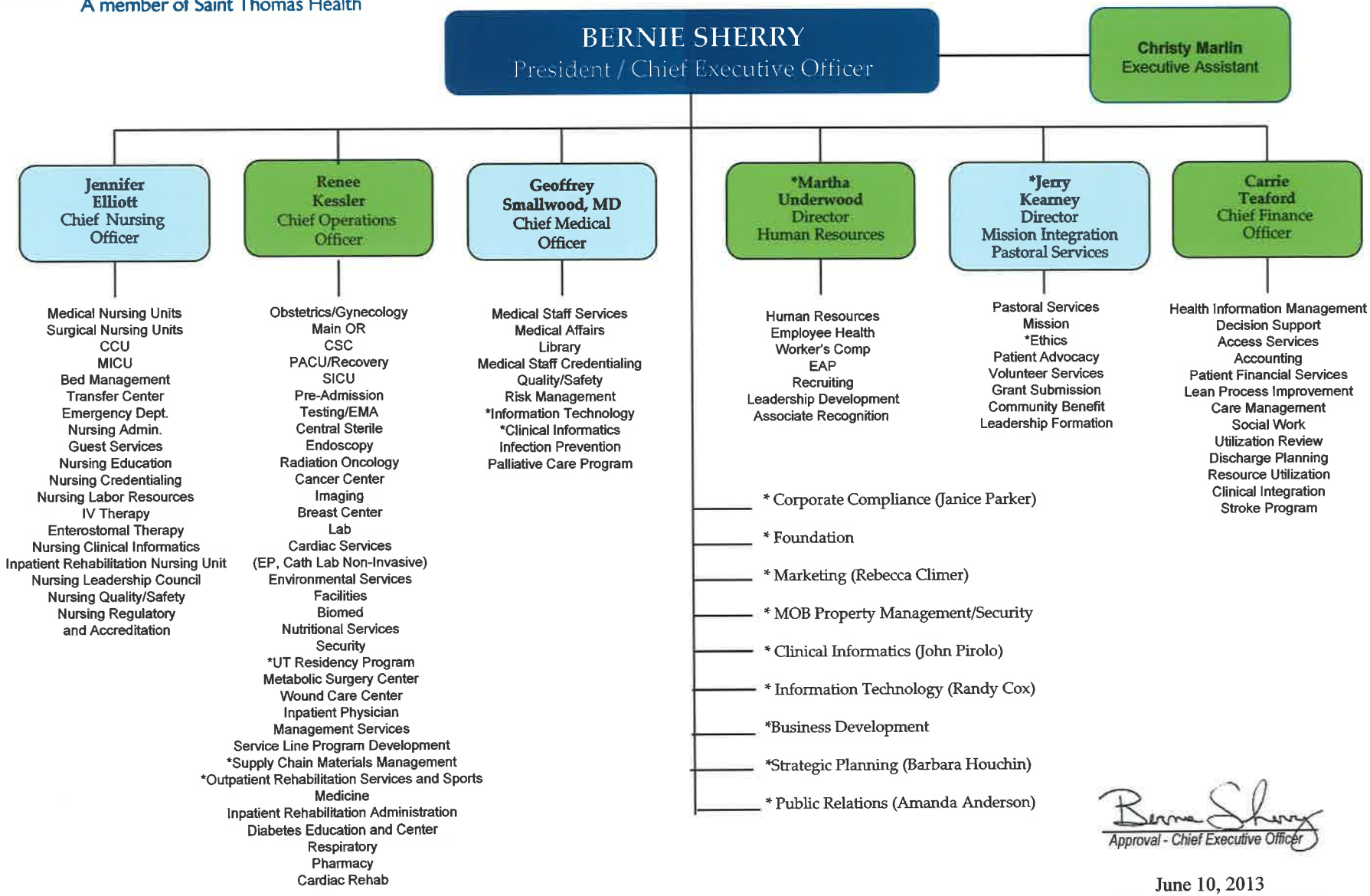
Attachment A, 4

Organizational Chart

Baptist Hospital

A member of Saint Thomas Health

Organizational Chart



*Matrix Relationship with Saint Thomas Health and Baptist Executive Team

Approval - Chief Executive Officer

June 10, 2013

Date Approved

Tab 3

Attachment A, 4

Board Roster

Baptist Hospital

A member of Saint Thomas Health

Board of Directors

Updated January 2013

Chairman	Mike Schatzlein, M.D.
Vice Chair	Karen Springer
Secretary/Treasurer	Craig Polkow

Tab 4

Attachment A, 4

Certificate of Corporate Existence

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

ROBERT LIMYANSKY
71 VICKERY STREET
ROSWELL, GA 30075

July 1, 2013

Request Type: Certificate of Existence/Authorization
Request #: 0101617

Issuance Date: 07/01/2013
Copies Requested: 1

Document Receipt

Receipt # : 1080402

Filing Fee: $22.25

Payment-Credit Card - TennesseeAnytime Online Payment #: 151059430 $22.25

Regarding: SETON CORPORATION
Filing Type: Corporation Non-Profit - Domestic
Formation/Qualification Date: 09/18/2001
Status: Active
Duration Term: Perpetual
Business County: DAVIDSON COUNTY

Control # : 414306
Date Formed: 09/18/2001
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

SETON CORPORATION

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent corporation annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 003339930

Tab 5

Attachment A, 6

Deed

This Instrument Was Prepared By:
Jack F. King, Jr., Esq.
Miller & Martin LLP
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

[Property No. 8]

Davidson County DEEDWARR
Recvd: 12/31/01 10:56 4pgs
Fees:23.00 Taxes:521867.65
20011231-0144935

Address New Owner(s):
Seton Corporation
4220 Harding Road
Nashville, TN 37201
Attention: President

Send Tax Bills to
New Owner

Map and Parcel Nos.:
92-11-368.00

SPECIAL WARRANTY DEED

FOR AND IN CONSIDERATION of the sum of Ten and no/100 Dollars ($10.00), cash in hand paid, and other good and valuable considerations, the receipt of which is hereby acknowledged, BAPTIST HOSPITAL SYSTEM, INC., a Tennessee non-profit corporation (the "Grantor"), has this day bargained and sold, and does hereby transfer and convey to SETON CORPORATION, a Tennessee corporation, (the "Grantee"), its successors and assigns, all those tracts or parcels of land described on Exhibit A attached hereto and made a part hereof, together with all rights, privileges, estates, easements, interests and appurtenances belonging or appertaining to said land, all buildings, fixtures and improvements located on the land, and all of Grantor's right, title and interest, if any, in and to the roads, streets, alleys and rights of way, whether open or closed, adjoining said land (collectively, the "real estate").

TO HAVE AND TO HOLD said real estate, with the appurtenances, estate, title and interest thereto belonging, to the said Grantee and its successors and assigns, forever. Grantor covenants with said Grantee that Grantor is lawfully seized and possessed of said land in fee simple subject to those matters set forth as Exhibit B and has a good right to convey it. Grantor further covenants and binds itself, its successors, and assigns to warrant and forever defend the title to said real estate against the lawful claims of all persons claiming by, through or under it, but no further or otherwise.

This is improved property known as 2000 Church Street, Nashville, Tennessee.

Whenever used, the singular shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

EXHIBIT A

A tract or parcel of land located in Nashville, Davidson County, Tennessee, being all of Unit 2 and Unit 3 of the Horizontal Property Regime known as Baptist Hospital created by that certain Master Deed of Baptist Hospital of record as instrument number 20011231-0144920, Register's Office for Davidson County, Tennessee.

Being part of the same property conveyed to Protestant Hospital of Nashville, Inc. by Deed from The Nashville Trust Company, a Tennessee corporation, as appointed receiver of Nashville Protestant Hospital of record in Deed Book 1237, page 440, Register's Office for Davidson County, Tennessee. Protestant Hospital, Inc. having since changed its name to Mid-State Baptist Hospital, Inc. by Amendment to Charter of record in Book 1605, page 533, Register's Office for said County. The said Mid-State Hospital, Inc. having since changed its name to Baptist Hospital System, Inc. by Articles of Amendment to the Charter recorded as instrument number 200009060087961, Register's Office for said County and also being part of the same property conveyed by Master Deed of record as instrument number _____, Register's Office for Davidson County, Tennessee.

Property No. 8
92-11-368.00

EXHIBIT B

PERMITTED EXCEPTIONS

1. Taxes for 2002, a lien not yet due and payable.

2. All matters as shown on Plat of record in Book 161, page 126, Register's Office for Davidson County, Tennessee.

3. A non-exclusive ingress and egress and parking easement created by Section 2.1(g) of the Reciprocal Easement Agreement of record in Book 10547, page 907, as amended in Book 10606, page 864, Register's Office for Davidson County, Tennessee.

4. Shared Services Agreement of record in Book 10511, page 466 and Book 10511, page 333, Register's Office for said County.

5. Unrecorded leases with parties in possession disclosed to Grantee.

6. Master Deed of record as instrument No. 20011231-0144920, Register's Office for Davidson County, Tennessee.

IN WITNESS WHEREOF, Grantor has executed this instrument on this 31st day of December, 2001.

BAPTIST HOSPITAL SYSTEM, INC.

By: Erie Chapman
Its: President

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared Erie Chapman with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be President of BAPTIST HOSPITAL SYSTEM, INC., the within named bargainor, a corporation, and that he as such President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

Witness my hand and seal, at office in Nashville, Tennessee, this 19th day of December, 2001.

Mary C. Ward
Notary Public

My Commission Expires: 11/26/2005

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $168,072,337.00

Thomas C. Burns
Affiant

Subscribed and sworn to before me
this 19th day of December, 2001.

Mary C. Ward
Notary Public
My Commission Expires: 11/26/2005

1:\ODMA\PCDOCS\TSD\273954\1

Tab 6

Attachment A, 13

MCO/BHO Participation

Baptist Hospital Managed Care Contracts List

Plan Name	Products/Network/Payor Name	Plan Type
Aetna / USHealthcare		
	Aetna HMO (Includes QPOS and US Access), Elect Choice (EPO), Managed Choice POS, Open Choice, Quality Point of Service (QPOS), US Access, National Advantage Plan, Aetna Select, Open Access Aetna Select, Aetna Open Access HMO, Aetna Open Access Elect Choice, Aetna Choice POS, Aetna Choice POS II, Aetna Open Access Managed Choice, Open Choice PPO, Traditional Choice, Aetna Affordable Health Choices PPO	HMO, EPO, POS, PPO, HMO/POS
	Aetna Golden Medicare Plan - HMO, Aetna Golden Choice Plan - PPO, Aetna Medicare Open Plan - Private FFS (PFFS)	Medicare Advantage
Aetna Institutes of Quality Bariatric Surgery Facility	IOQ Bariatric Surgery	Center of Excellence
Aetna Institutes of Quality Orthopedic Care	IOQ Joint Replacement	Center of Excellence
	IOQ Spine Surgery	Center of Excellence
Alive Hospice	Alive Hospice	Direct
Americhoice	Americhoice (aka United HealthCare Plan of the River Valley, Inc.) (Includes Dual Eligible Special Needs Plan - SNP)	TennCare HMO
AMERIGROUP Community Care		
	AMERIGROUP Community Care	TennCare HMO
	AMERIVANTAGE Medicare Advantage (Includes Dual Eligible Special Needs Plan - SNP)	Medicare Advantage
Avalon Hospice (formerly Trinity Hospice) (STH, MTMC and Hickman added eff. 2/1/10)	Trinity Hospice	Hospice (Inpatient services for Medicare and TennCare Patients)
Beech Street (A Viant Company) (formerly Concentra, Concentra Preferred Systems, Health Network Systems, PPONext, CapCare, MediChoice) *(Purchased by MultiPlan, but networks remain separate until further notice)*	Beech Street (Includes Beech Street Primary Network, Beech Street Complementary Network and Viant Supplemental Networks)	PPO
BC/BS of TN (BCBST)		
	BlueAdvantage and BlueAdvantage Plus (PFFS) *It is a unique program in that members may use any doctor, specialist or hospital that accepts the BlueAdvantage terms, conditions and payment rate. Prior to providing services to a BlueAdvantage member, providers must agree to the Terms and Conditions of Plan Payment. When Providers choose to extend services to a BlueAdvantage member, they are acknowledging their agreement and are "deemed" to have a contract with BlueCross BlueShield of Tennessee.*	Medicare Advantage Private Fee for Service (PFFS)
	BlueAdvantage Local PPO (effective 1/1/2009)	Medicare Advantage
	Medicare Advantage Regional PPO (effective 9/20/09)	Medicare Advantage
	BlueCoverTN / Blue Network V	PPO
	Access TN (uses BlueSelect / Network S)	PPO
	Cover Kids (uses Blue Select / Network S)	PPO
	Blue Preferred / Network P (includes Suitcase PPO Program/ BlueCard and Federal Employees Standard Option and Basic Option Programs)	PPO
	Blue Select / Network S (Includes Suitcase PPO Program/BlueCard)	PPO
CCN (National network owned by First Health)	CCN (consolidated under First Health Network as of 1/1/07)	PPO
Blue Distinction Center for Bariatric Surgery	Blue Distinction Center for Bariatric Surgery	Center of Excellence
Blue Distinction Center of Knee and Hip Replacement	Blue Distinction Center for Knee and Hip Replancement	Center of Excellence
Blue Distinction Center for Spine Surgery	Blue Distinction Center for Spine Surgery	Center of Excellence

Plan Name	Products/Network/Payor Name	Plan Type
Bluegrass Family Health	Bluegrass Family Health	HMO, PPO, POS, Consumer Directed Health, including HRA and HSA, Self Insured / TPA, Network Leasing
CenterCare Managed Care Programs	Center Care	PPO, POS
Cigna Healthplan		
	Cigna Healthplan PPO (Includes Starbridge Choice and Great West PPO)	PPO
	Cigna Healthplan HMO and Gatekeeper POS (Includes HMO Fully Insured, Open Access Plus and Network and Great West HMO and POS)	HMO / POS
	Cigna Medicare Access, Cigna Medicare Access Plus Rx (No provider networks or contracts. Members can visit any provider who accepts original Medicare payment and also Cigna's terms and conditions of payment.)	Medicare Private Fee For Service
CorVel Corporation	CorCare	WC
Coventry Health Care (formerly First Health Direct)	Coventry Health Care (formerly First Health Direct) (As of 1/1/07, this replaced the First Health Direct business. It is the directly administered commercial business	PPO
Division of Rehabilitation Services	Division of Rehabilitation Services	Direct
First Health	First Health (As of 1/1/07, this network is part of Coventy Health Care's rental network business, including group health and workers comp. The following networks will be consolidated under the First Health name: CCN, Healthcare Value Management (HCVM) and PPO Oklahoma)	Rental Network (PPO)
FOCUS Healthcare Management *(a wholly owned susidary of Concentra)*	FOCUS	WC
Great West (formerly known as One Health Plan)		
	Great West / One Health Plan / PPO *(As of 2/1/09, plan will access Cigna PPO)*	PPO
	Great West / One Health Plan / HMO *(As of 2/1/09, plan will acesss Cigna Managed Care)*	HMO
	Great West / One Plan /POS *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
	Great West / Open Access) *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
HealthMarkets Care Assured	Health Markets Care Assured PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and HealthMarkets Care Assured's policies)*	Medicare Advantage Private Fee for Service (PFFS)
Health Payors Organization, Ltd. / Interplan Healthgroup	HPO	PPO
HealthSpring (fka Healthnet Management Co.)		
	HealthSpring HMO, Inc. (Commercial Plans include Primary Plan, Advantage Plan, Freedom Plan, Direct Product Plan and Member Option Plan)	HMO, POS and EPO
	HealthSpring Medicare Advantage	Medicare Advantage
Humana Health Care Plans		
	Humana HMO, POS, PPO (Including Choice Care) (Includes CHA Prime Network for fully insured HMO, POS and PPO as of 1/1/2009)	HMO, POS PPO
	HumanaChoice PPO and Humana Gold Plus HMO	Medicare Advantage (Contracted)
	Humana Gold Choice Medicare Advantage PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facilitywho accepts Medicare and Humana's terms)*	Medicare Private Fee For Service
KY Medicaid	KYHealth Choices, including Global Choices, Family Choices, Optimum Choices and Comprehensive Choices (KY Medicaid)	Medicaid
MultiPlan (includes BCE Emergis / ProAmerica) *(MultiPlan purchased PHCS and Beechstreet/Viant. Networks will remain separate until further notice)*	MultiPlan, BCE Emergis, ProAmerica, Up and Up, Formost	PPO

Plan Name	Products/Network/Payor Name	Plan Type
NovaNet	Nova Net	PPO
OccuComp *(Only Outpatient Rehabilitiation Services)*	OccuComp	WC
Odyssey Healthcare	Odyssey Healthcare	Hospice (Inpatient services for Medicare and TennCare Patients)
Prime Health (formerly known as Comp Plus)		
	Prime Health (formerly known as CompPlus)	
	Workers Compensation	WC
	Tier I Commmercial	PPO
	Tier II Commercial	PPO
Private Healthcare Systems, Ltd. *(Purchased by MultiPlan. Networks will remain separate until further notice)*	Private Healthcare Systems (PHCS)	PPO & PPO/POS
Pyramid Life - Today's Options	Today's Options Medicare Advantage Private Fee for Service (No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and Pyramid's terms)	Medicare Advantage Private Fee for Service (PFFS)
Signature Health Alliance *(BlueGrass purchased Signature Health Alliance. Effective 4/1/10, contracted under BlueGrass with two tiers of payment)*	Signature Health Alliance	PPO
Southern Benefit Administrators, Inc.	Southern Benefit Administrators, Inc.	TPA
Starbridge Choice *(Plan falls under Cigna PPO network)*	Starbridge Choice	PPO
Sterling Healthcare (Option 1) *(No contract required)*	Option I	Medicare Advantage, Private Fee for Service
TriCare for Life *(No contract required)*	TriCare for Life	Medicare Supplement for retired military
TRICARE North (HealthNet Federal Services)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
TRICARE South (Humana Military)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
United Healthcare	United Healthcare: Choice, Choice Plus, Select, Select Plus, Options PPO, Definity HRAs and HSAs	HMO, PPO, POS
	Secure Horizons (fka United Healthcare Medicare Complete)	Medicare Advantage
USA Managed Care Organization		
	PPO: Includes USA H&W and USA WIN (PPO includes Tennessee Healthcare Group Health)	PPO
	EPO: Includes USA SPAA and USA WIN SPAA (EPO includes Tennessee Healthcare Work Comp) (As of 9/20/2006, Tennessee Healthcare began accessing USA MCO with the exception of State of TN Public Employees (Work Comp) which will remain with Prime Health through 2007)	EPO
Windsor HealthCare	Windsor HealthCare Medicare Advantage	Medicare Advantage

Attachment B

Plot Plan
Maps of Service Area Access
Schematics

Tab 7

Attachment B, III.(A)

Plot Plan

Baptist Hospital

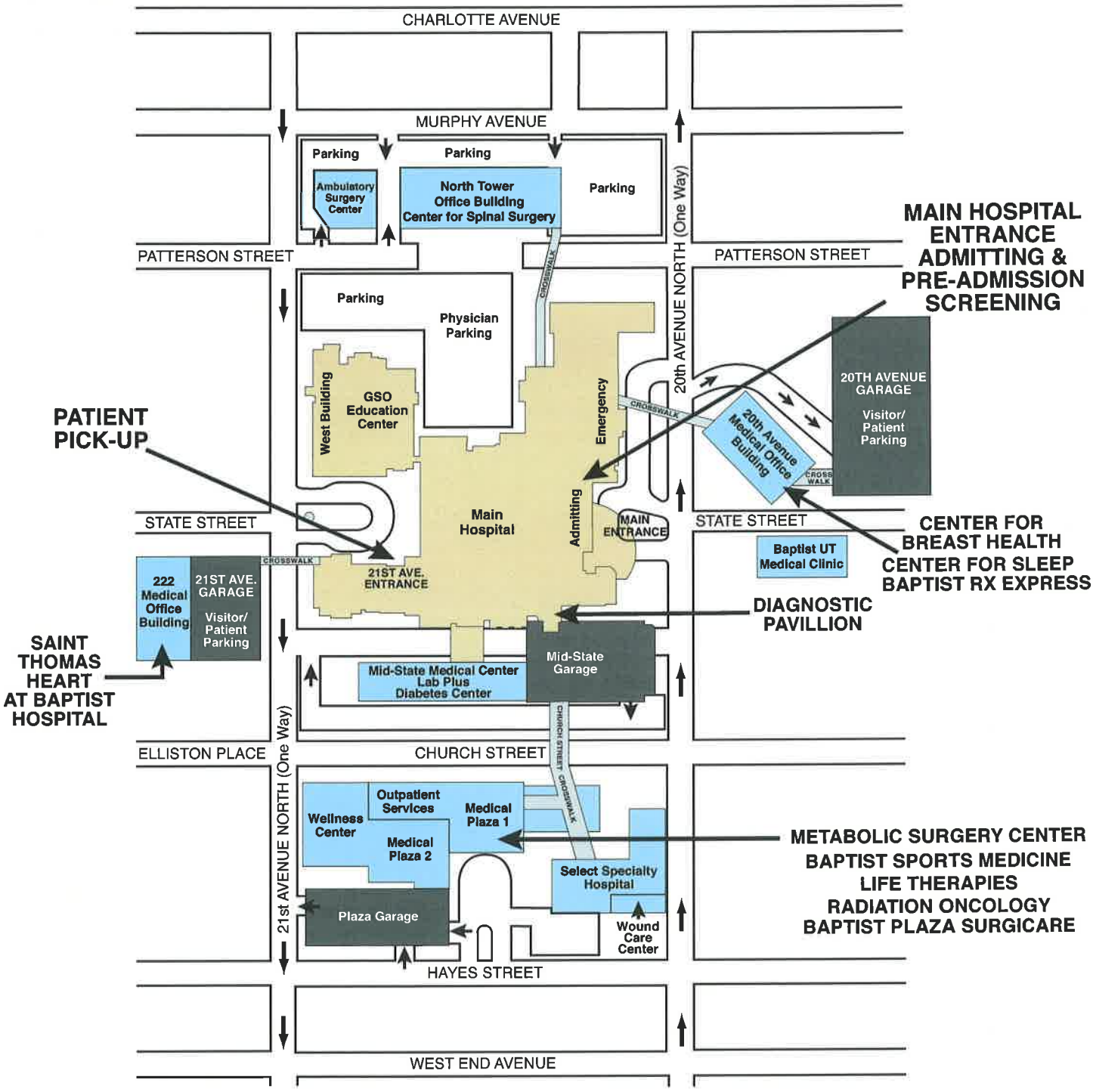
A Member of Saint Thomas Health Services

Campus Map

2000 Church Street, Nashville, Tennessee 37236
(615) 284-5555 • www.BaptistHospital.com

Patient Information (615) 284-5288

Baptist Hospital is a tobacco free campus.



Free parking is available for patients and visitors in the 21st Avenue, 20th Avenue and Plaza parking garages. The Mid-State Garage offers free parking for Mid-State Medical Center, obstetrics, joint replacement center and cardiovascular lab patients only (no visitor parking). Free valet parking is available Monday to Friday from 6 a.m. to 4 p.m. at the 20th Avenue Main Entrance to the hospital.

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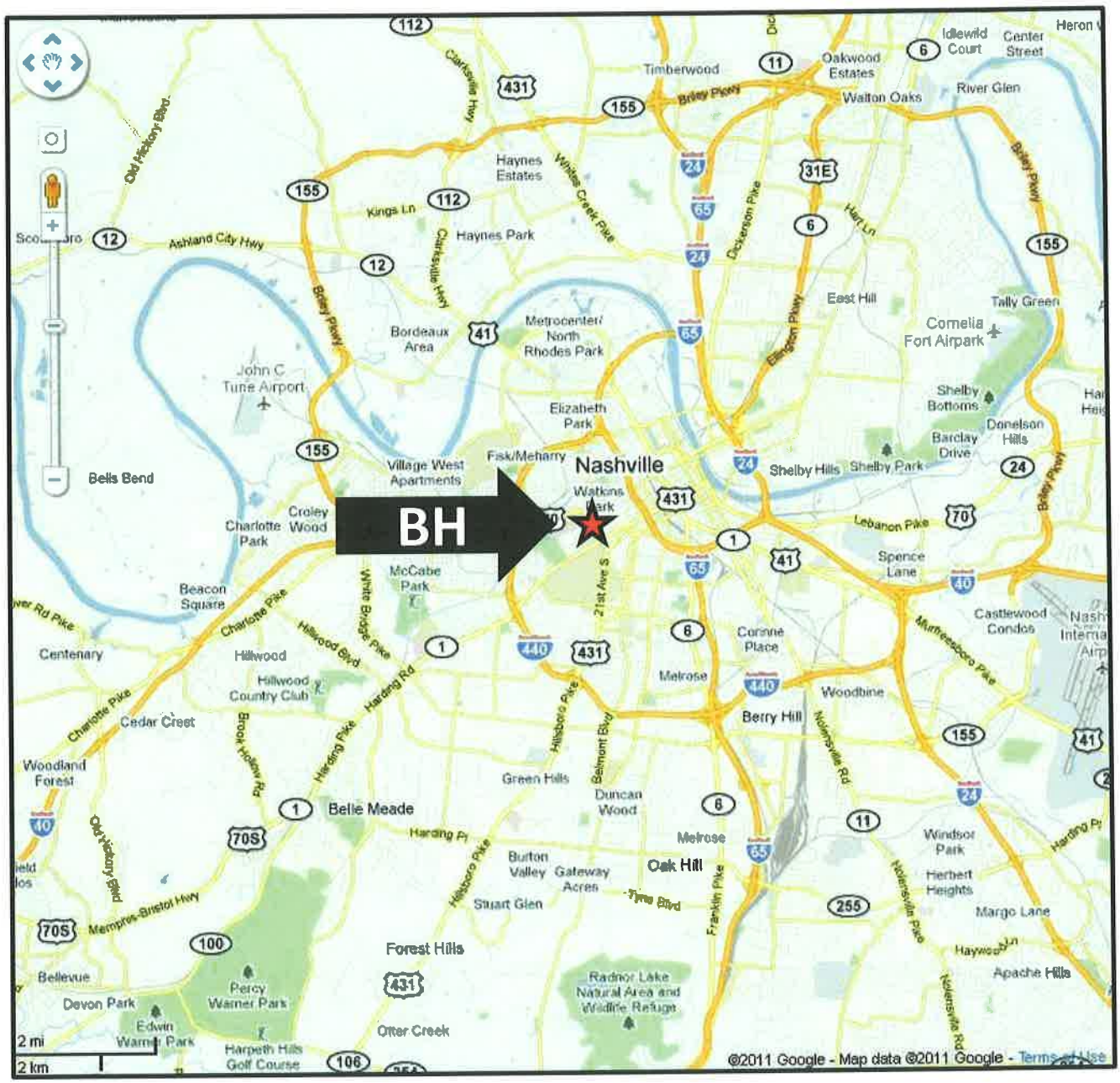
Tab 8

Attachment B, III.(B).1

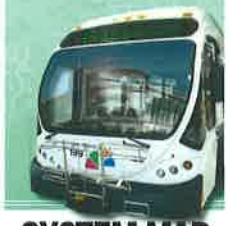
Maps of Service Area Access

Access to Baptist Hospital



Nashville MTA

Your ticket to Music City



SYSTEM MAP

EFFECTIVE March 31, 2013

MTA Displays Around Town

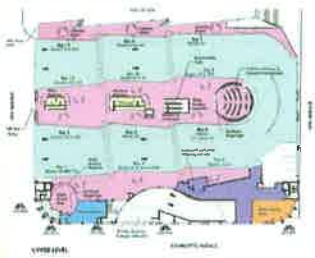
Display Racks of Schedules

1. Andrew Jackson Building, 500 Deaderick Street
2. Andrew Johnson Building, 710 James Robertson Parkway
3. Anthem Career College, 580 Royal Parkway
4. Belmont University, 1900 Belmont Boulevard
5. Bridgestone Arena, 501 Broadway
6. City Hall & Metro Courts, 1 Public Square
7. Daymar Institute, 340 Plus Park Boulevard
8. Davy Crockett Building, 500 James Robertson Parkway
9. Justice A.A. Birch Building, 408 2nd Avenue North
10. Lentz Public Health Center, 311 23rd Avenue North
11. Looby Career and Library, 2301 Rosa L. Parks Blvd
12. Metro Board of Education 2601 Bransford Avenue
13. Metro General Hospital, 1818 Albion Street
14. MTA Madison Headquarters, 430 Myatt Drive
15. Music City Central, 400 Charlotte Avenue
16. Nashville Auto Diesel College, 1524 Gallatin Road
17. Nashville Downtown Library, 615 Church Street
18. Peabody College Post Office, 230 Appleton Place
19. Riverfront Regional Rail Station, 108 1st Ave. North
20. Tennessee Dept. of Human Services, 1000 2nd Avenue North
21. Tennessee Performing Arts Center, 505 Deaderick Street
22. Tennessee State University, 3500 John A. Merritt Blvd
23. Vanderbilt University Post Office, 2301 Vanderbilt Place
24. Watkins College of Art, Design & Film 2298 Rosa L. Parks Boulevard
25. William R. Snodgrass Tennessee Tower, 311 7th Avenue North

For a list of other locations, please call MTA Customer Care at **(615) 862-5950**.

MUSIC CITY CENTRAL

UPPER LEVEL



This state-of-the-art facility is located at 400 Charlotte Avenue between 4th and 5th Avenues North in the Central Business District (CBD).

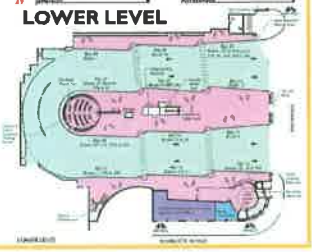
It serves as the central hub for MTA buses. There are climate-controlled waiting rooms, an MTA staffed information and ticket sales center; customer restrooms and small retail businesses, including Dunkin' Donuts and the Music City Market.

Up to 20,000 customers use the facility each weekday.

MAP KEY

- Bus Lane
- Passenger Waiting Area
- Retail Space
- Office Space
- Public Meeting Room
- Customer Seating
- Bike Rack

LOWER LEVEL



Route	Bay	Route	Bay
1 00 Oaks	15	26 McFerrin	12
2 Belmont	14	Hickory Hollow/Lenox Express	18
3 West End/White Bridge	5	34 Opry Mills	10
4 Shelby	14	Rivergate Express	17
5 West End/Bellevue	5	Madison Express	17
6 Lebanon Pike	10	Tusculum/McMurray Express	17
7 Hillsboro	9	Antioch Express	17
8 8th Avenue South	9	Cane Ridge Express	20
9 MetroCenter	11	Golden Valley	13
10 Charlotte	21	41 St. Cecilia/Cumberland	6
12 Nolensville Pike	13	43 Hickory Hills	13
14 Whites Creek	3	44 MTA Shuttle	20
15 Murfreesboro Pike	16	55 Murfreesboro Pike BRT lite	11
17 12th Avenue South	19	56 Gallatin Pike BRT lite	11
18 Airport/Downtown Hotels	19	Murfreesboro Express	13
19 Herman	4	Smyrna/La Vergne Express	13
20 Scott	16	Gallatin Express	18
21 Bordeaux	7	Springfield/Joelton Express	8
22 Dickerson Road	12	Franklin/Brentwood Express	11
Bellevue Express	9	Hendersonville Express	19
25 Midtown	20 & 21	Clarksville Express	12
26 Gallatin Pike	3	Spring Hill Express	7
Old Hickory	8	Nashville/Murfreesboro Relax & Ride	22
28 Meridian	12	Harding & Belle Meade	23
29 Jefferson	1	Access Ride	3

Welcome aboard!

Whether you are a resident or a visitor to Music City, we are pleased that you are considering riding or already utilizing our transit system. With 46 bus routes and related services, we can connect you to all major corridors and many major businesses and tourist attractions. And with a record 10 million passenger trips on MTA & RTA vehicles last year, demand for public transportation has never been higher.

On March 31, we expanded and improved services on MTA's route that serves the Nashville airport. Early morning and evening trips have been added to the airport service, and the routing now serves the new Music City Center convention center and downtown hotels.

Please also take advantage of MTA's FREE downtown circulator, the Music City Circuit, a convenient and efficient way to get around downtown Nashville and the Gulch. Three different routes offer frequent service connecting the Riverfront Train Station and many points of interest in the downtown area.

Nashville MTA has introduced the Rapid Transit (BRT) to Music City. After a successful pilot versions of the rapid service on the Gallatin Pike corridor, we are now operating a similar BRT lite service along the busy Murfreesboro Pike corridor. Brand-new hybrid vehicles provide faster, more frequent service using traffic signal extenders, which allow traffic lights to remain green as the vehicles approach an intersection. Passengers ride in comfort, and new bus shelters provide real-time digital updates.

Last fall, a new cross-town University Connector came on line, connecting six universities: Tennessee State University, Meharry Medical College and Vanderbilt University Medical Center, Vanderbilt University, Belmont University and Lipscomb University. Riders have easy access to 10 other bus routes at various transfer points. The University Connector joins the Midtown, Airport Connector, and Edmondson Pike Connector on our system's fourth cross-town route.

The MTA board and its transit constituents are working diligently to provide transportation services that will be of increasing importance to you and the Nashville community. MTA also will continue to be one of the thousands who rely on our transit services to get you to your destinations.

Thomas F. "Freddie" O'Connell
MTA Board Chair

Frequency Chart

(Average number of minutes between bus trips unless otherwise indicated)

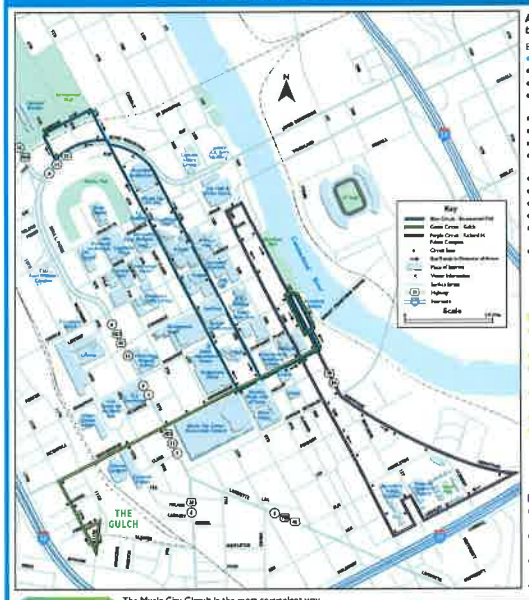
ROUTE	NAME	MONDAY-FRIDAY AM Rush	MONDAY-FRIDAY Midday	MONDAY-FRIDAY PM Rush	MONDAY-FRIDAY Evening	SATURDAY Daytime	SATURDAY Evening	SUNDAY All Day
1	100 Oaks	60	—	60	—	—	—	—
2	Belmont	40	—	40	—	—	—	—
3,5	Core trips for routes 3, 5	10	15	10	20	20	20	20
3	West End/White Bridge	20	30	20	40-60	40	40-60	40
4	Shelby	20	30	20	40-60	40	40-60	40-60
5	West End/Bellevue	20	30	20	40-60	40	40	40
6	Lebanon Pike	15-35	90	15-35	60	—	—	—
7	Hillsboro	20	20	20	40	40	40-60	40-60
8	8th Avenue South	35	75	35	60	60-240	60	60-240
9	MetroCenter	30	30	30	—	—	—	—
10	Charlotte	25	25	25	40	45	45	45
12	Nolensville Pike	10-15	20-30	10-20	60	40	60	60
14	Whites Creek	30	60	25-35	60	60	60	60
15,55	Core trips for routes 15, 55	10-15	10-15	10-15	20-30	10-30	10-30	40
15	Murfreesboro Pike	40	40	40	60	60	60	40
17	12th Avenue South	20-35	20-35	25-35	60	30-60	60	60
18	Airport/Downtown Hotels	60	60	60	60	60	60	60
19	Herman	20	30	20	60	60	60	60
20	Scott	25-30	70	30	60	60	60	60
21	University Connector	30	60	30	60	60	60	60
22	Bordeaux	15-20	22	17	60	30-60	60	60
23	Dickerson Road	20	25	20	60	40	60	60
Bellevue Express	Bellevue Express	4 Trips	—	5 Trips	—	—	—	—
25	Midtown	35	60	35	60	60	60	60
26,56	Core trips for routes 26, 56	10-15	10-15	10-15	20-30	10-30	10-30	40
26	Gallatin Pike	40	40	40	60	60	60	40
Old Hickory	Old Hickory	2 Trips	—	2 Trips	—	—	—	—
28	Meridian	25	50	25	50	50	50	50
29	Jefferson	20	30	20	60	60	60	60
30	McFerrin	60	60	60	60	60	60	60
Hickory Hollow/Lenox Express	Hickory Hollow/Lenox Express	2 Trips	1 Trip	3 Trips	—	—	—	—
34	Opry Mills	90	90	90	90	90	90	90
Rivergate Express	Rivergate Express	3 Trips	—	4 Trips	—	—	—	—
Madison Express	Madison Express	3 Trips	2 Trips	3 Trips	—	—	—	—
Tusculum/McMurray Express	Tusculum/McMurray Express	2 Trips	—	2 Trips	—	—	—	—
Antioch Express	Antioch Express	2 Trips	—	3 Trips	—	—	—	—
Cane Ridge Express	Cane Ridge Express	2 Trips	—	3 Trips	—	—	—	—
Golden Valley	Golden Valley	60	—	60	—	—	—	—
41	St. Cecilia/Cumberland	30-55	50-65	25-30	60	60	60	60
43	Hickory Hills	25-50	125-150	50-60	—	—	—	—
44	MTA Shuttle	30	20-25	30	—	—	—	—
55	Murfreesboro Pike BRT lite	15	15	15	30	30	30	—
56	Gallatin Pike BRT lite	15	15	15	30	30	30	—
Edmondson Pike Connector	Edmondson Pike Connector	60	60-180	60	60	—	—	—
76	Madison Connector	60	60	60	60	60	—	—
Murfreesboro Express	Murfreesboro Express	3 Trips	—	3 Trips	—	—	—	—
Smyrna/La Vergne Express	Smyrna/La Vergne Express	3 Trips	—	3 Trips	—	—	—	—
Gallatin Express	Gallatin Express	2 Trips	—	3 Trips	—	—	—	—
Springfield/Joelton Express	Springfield/Joelton Express	2 Trips	—	2 Trips	—	—	—	—
Franklin/Brentwood Express	Franklin/Brentwood Express	3 Trips	—	3 Trips	—	—	—	—
Hendersonville Express	Hendersonville Express	2 Trips	—	3 Trips	—	—	—	—
Music City Star West End Shuttle	Music City Star West End Shuttle	3 Trips	—	3 Trips	—	—	—	—
Clarksville Express	Clarksville Express	3 Trips	—	3 Trips	—	—	—	—
Spring Hill Express	Spring Hill Express	2 Trips	—	2 Trips	—	—	—	—
Nashville/Murfreesboro Relax & Ride	Nashville/Murfreesboro Relax & Ride	4 Trips	8 Trips	4 Trips	3 Trips	—	—	—

Key to Routes

- **Most frequent routes** (Daytime frequencies every 30 minutes or less)
- **Frequent routes** (Daytime frequencies generally 30-90 minutes)
- **Limited services** (Limited or express service)

This frequency chart is not definitive and should only be used as a guide. Please consult individual route schedules for further information.

MUSIC CITY CIRCUIT



Attractions along the routes:

Blue Circuit
- Arcade
- Bicentennial Mall
- Bridgestone Arena
- Country Music Hall of Fame
- Farmers' Market
- Hatch Show Print
- Municipal Auditorium
- Music City Center (Convention Center)
- Music City Central
- Printers Alley
- Riverfront Station
- Ryman Auditorium
- Schermerhorn Symphony Center
- Tennessee State Museum

Green Circuit
- Country Music Hall of Fame
- Cummins Station
- Gulch Restaurants and Bars
- Music City Center (Convention Center)
- Riverfront Station
- Schermerhorn Symphony Center

Purple Circuit
- City Hall & Metro Courts
- Nashville Children's Theatre
- Richard H. Fulton Complex
- Riverfront Station

The Music City Circuit is the most convenient way to get around downtown Nashville and the Gulch. Whether you live or work downtown or you're visiting for business or pleasure, the Music City Circuit will get you where you need to go quickly and easily. Dining, entertainment and shopping are all at your fingertips without parking hassles, and our clean-fuel vehicles help lower vehicle emissions.

Frequent stops all around downtown and the Gulch make it a breeze to get to your favorite restaurant, the hottest concert, or anywhere else in between. Just board the Music City Circuit at one of the designated stops with the blue-and-green sign.

	MONDAY-FRIDAY AM	MONDAY-FRIDAY Midday	MONDAY-FRIDAY PM	MONDAY-FRIDAY Evening	SATURDAY Daytime	SATURDAY Evening
Blue Circuit	30	15	15	—	15	—
Green Circuit	30	15	15	15	15	15
Purple Circuit	—	15	—	—	—	—

General Information

Bus Stops
Most MTA bus stops are marked with a blue-and-white sign. If bus stop signs have not yet been installed on your bus route, please go to the nearest intersection of the street traveled by your bus and flag it down when it comes into view.

Destination Signs
Every MTA bus is marked with a route number as well as the destination name or area. All Express Routes are designated by an "X" following the route number. As you get on an MTA bus, if you have questions about where the bus is going, please ask the driver.

Park & Ride
Several bus routes provide Park & Ride service that allows you to park your car and ride an MTA bus. MTA passengers are permitted to use Park & Ride lots as complimentary services by owners of the lots. Please refer to the list above the system map or on the route schedules for locations.

Holiday Service
On the following major holidays MTA operates service on a Sunday/Holiday schedule:
- New Year's Day
- Labor Day
- Memorial Day
- Thanksgiving
- Independence Day
- Christmas

On Martin Luther King Jr. Day, MTA operates service on a Saturday schedule.

Services for Medicare Cardholders, Seniors or People with Disabilities
Medicare cardholders, who are not elderly or disabled, qualify for a reduced MTA fare of 85 cents on MTA buses with their Medicare ID. Seniors age 65 and older and people with disabilities qualify for a reduced MTA fare of 85 cents on MTA buses with one of the following ID cards: Medicare, Seniors-MTA Golden Age, or driver's license. Disabled-Medicare, MTA Special Service, or other transit ID card for the disabled. Passengers whose disabilities prevent them from using the large MTA buses may qualify for special door-to-door van service through the MTA AccessRide Program. Please call the MTA AccessRide Office at **(615) 880-3970** for more information or visit the MTA website at nashvillemta.org.

Snow Routes
Be prepared for winter weather and pick up your MTA snow route brochure today.
Snow route information may be found at MTA displays around town, on MTA buses, online at nashvillemta.org or by calling Customer Care at **(615) 862-5950**.

Music City Central
Music City Central serves as the central hub for MTA buses and is the main transfer point. It is located at 400 Charlotte Avenue between 4th and 5th Avenues North in the Central Business District.

AccessRide

MTA's paratransit service operates a fleet of special vans for people with disabilities who are unable to ride the large fixed-route buses.

- This door-to-door service is provided within Davidson County.
- To request an eligibility application, call AccessRide at **(615) 880-3970** or download a copy from the MTA website at nashvillemta.org.

How Much are the Fares?

Adult
Adult (Local, Airport & BRT lite Services) $1.70
Adult (Express Service) $3.25
Senior (ages 65 and older, please show driver proof of age before depositing fare) ..... $ .85
People with Disabilities and Medicare cardholders *(please show driver special identification card before depositing fare)* ..... $ .85

Youth
Youth Fare (ages 19 and younger, please show driver before depositing fare and be prepared to show proof of age upon request) $1.00
Children ages 4 and younger ..... No Charge

MTA Passes Available – For your convenience, passes are available for purchase at Music City Central (400 Charlotte Avenue), by phone at **(615) 862-5950** or online at nashvillemta.org. In addition, passes may be requested via mail by sending the request to the MTA Administrative Office address. The All-Day Pass also is available for purchase on MTA buses.

All-Day Pass	$3.25
All-Day Discounted Pass	$3.25
All-Day Youth Pass	$3.50
20-Ride Local	$32.00
20-Ride Express	$42.00
7-Day Pass	$24.00
31-Day Pass	$84.00
20-Ride Discounted Pass	$17.00
31-Day Discounted Pass	$44.00
Quest 7-Day Youth Pass	$16.00
Quest 31-Day Youth Pass	$58.50

- MTA's passes are valid for trips within Davidson County and are not valid for RTA services.

Express Upgrades – Deposit an extra 50 cents to use a 20-Ride Local Pass on an express bus.

Cash, checks, money orders and credit cards are accepted for these purchases. A $2.50 shipping fee will be applied to all mail, phone and online orders.

000086

For more information on BusLink, call Customer Care at **(615) 862-5950**.

Travel Training

Travel Training or "Bus Riding 101" is a service that teaches people with and without disabilities how to ride Nashville MTA buses. Trainers work one-on-one with customers to give them the practice they need to feel confident riding MTA buses. Group orientations, including trips on buses to destinations on our many bus routes, also are available.

There is no charge for travel training; however, individuals must pay the standard bus fare. Seniors age 65 and older, people with disabilities, Medicare cardholders and youth ages 19 and younger are eligible for a discounted fare.

For more information, call **(615) 880-3597** or visit our website at nashvillemta.org.

Antioch's BusLink Service

Need transportation in and around Antioch? We offer an on-demand shuttle service called BusLink that you will want to use. Just call **862-LINK (5465)** and ask a scheduler to pick you up and take you to one of our convenient stops within the demand zone all for the same cost as an MTA bus fare.

- BusLink runs Monday through Friday from 5 a.m. to 7 p.m. and on Saturday from 10 a.m. to 5 p.m. in the Antioch area. The designated zone includes more than 40 stops, so there is sure to be one close to you.
- If you need to travel outside of the zone, board a Route 15 Murfreesboro Pike bus or Route 55 Murfreesboro Pike BRT lite bus at Murfreesboro Pike and Bell Road. Each hour, BusLink will make a scheduled connection at this location.

Transit Partnerships

Google maps

MTA partners with Google to provide customers with a public transit trip planning feature on Google maps.

EasyRide

EasyRide

This service is designed to help employers incorporate commuter benefits into their benefits plan. For more information, contact MTA at **(615) 862-5969** or ask your Human Resources Director about commuter benefits.

To receive the latest MTA news in your e-mail inbox, sign up for our eNews service at nashvillemta.org.

MTA Office Hours

Customer Care Call Center
(615) 862-5950
- Monday-Friday 6:30 a.m. to 6:30 p.m.
- Saturday 8:00 a.m. to 5:00 p.m.
- Sunday 10:30 a.m. to 2:30 p.m.
- Closed holidays

Ticket Sales and Information at Music City Central
400 Charlotte Avenue
- Monday-Friday 6:00 a.m. to 6:30 p.m.
- Saturday 8:00 a.m. to 5:00 p.m.
- Sunday 10:30 a.m. to 2:30 p.m.
- Closed holidays

Music City Central – Hours of Operation
400 Charlotte Avenue
- Monday-Friday 5:15 a.m. to 11:15 p.m.
- Saturday 6:00 a.m. to 10:15 p.m.
- Sunday and holidays 6:00 a.m. to 9:15 p.m.

MTA Administrative Offices
(615) 862-5969
430 Myatt Drive, Nashville, TN 37115
- Monday-Friday 8:00 a.m. to 4:30 p.m.
- Closed weekends and holidays

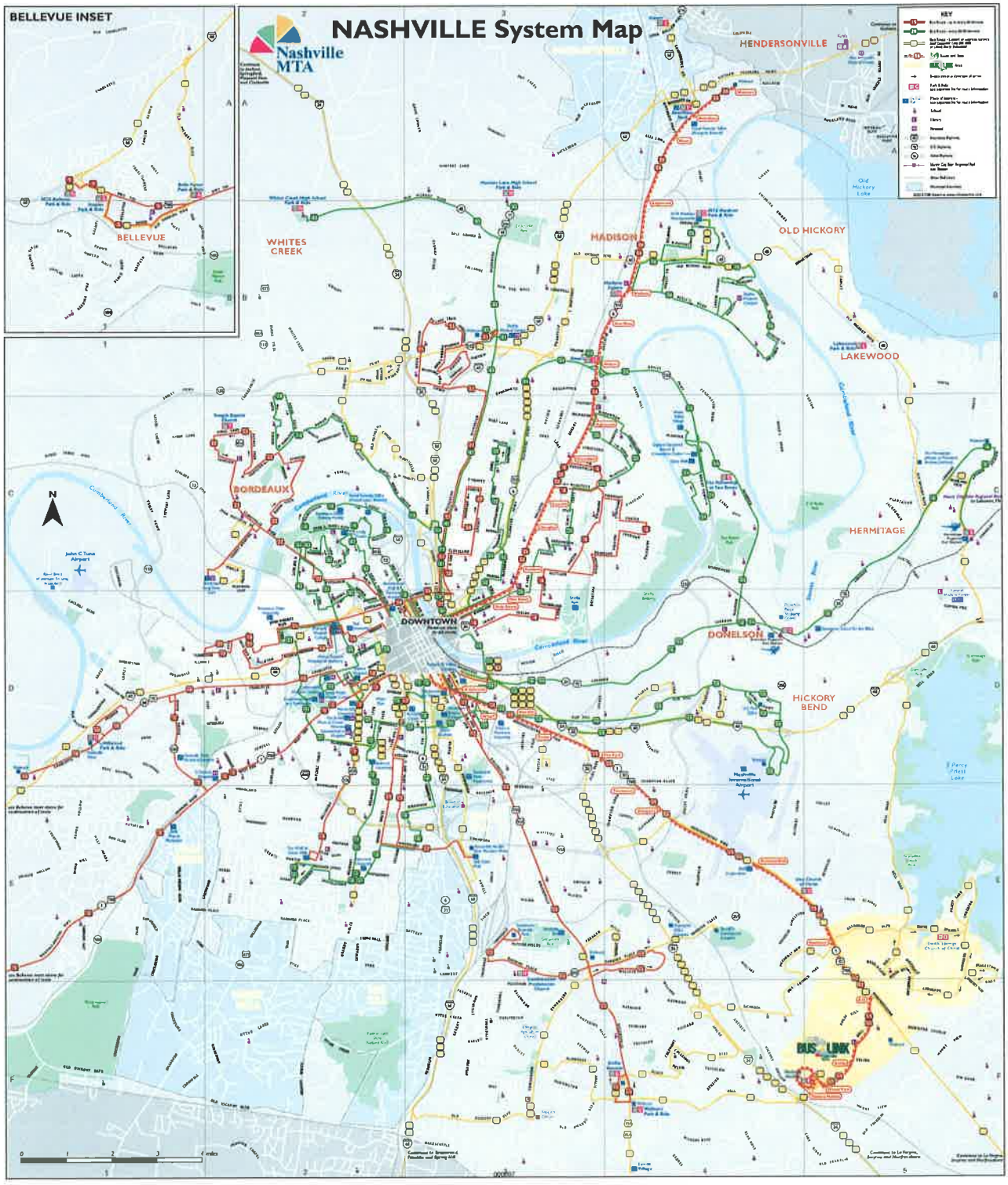
Metropolitan Transit Authority
430 Myatt Drive, Nashville, TN 37115
ADA Coordinator and Customer Care:
(615) 862-5950 nashvillemta.org
@Nashville_MTA

Points of Interest

No.	Location	Served by Route	Grid Ref.
1	100 Oaks Mall	1, 17	C2
2	Adventure Science Center	1, 28	D2
3	Airport, Nashville International	18	D4
4	Baptist Hospital	18, 28	D2
5	Belle Meade Plantation	8	E1
6	Belmont University	1, 51	D2
7	Bicentennial Mall & Farmers' Market	19, 22, 29, 42	D2
8	Bordeaux Long Term Care	23	C2
9	Bridgestone Arena	12, 15, 18, 34, 55 BRT Blue	Downtown
10	Centennial Medical Center	18, 28	D2
11	Centennial Park & Parthenon	2, 6, 25	D2
12	City Hall & Metro Courts	24, 28, 34, 55X, 61	Downtown
13	Country Music Hall of Fame	12, 15, 18, 55 BRT Blue	Downtown
14	Criminal Justice Center	24, 55X, 61	Downtown
15	Dell Corporation	15, 55 BRT Blue	E4
16	Donelson Regional Rail Station	4, 59	E4
17	Downtown Library	1, 3, 7, 8, 17, 55X	Downtown
18	Fisk University	19, 21, 25, 29	D2
19	Fort Nashborough	1, 15, 34, 55X, 64, 93	Downtown
20	Frist Center for the Visual Arts	1, 3, 7, 17	Downtown
21	Gaylord Opryland Resort & Convention Center	24	C4
22	Greer Stadium	1, 28	D3
23	Greyhound Bus Station	15, 18, 18, 55 BRT Blue 84X, 86X, 96X	D2
24	Hermitage Regional Rail Station	4, 59	C5
25	Justice A.A. Birch Building	24, 28, 34, 55X, 61	Downtown
26	Juvenile Justice Center	4, 14, 20, 22, 43	Downtown
27	Lenox Village	55X	F4
28	Lentz Public Health Center	18, 28	D2
29	Lipscomb University	5, 6, 51	E3
30	Lundy Center	9, 43	C2
31	LP Field	4, 14, 20, 22, 43	Downtown
32	The Mall at Green Hills	7, 9, 51	E3
33	Meharry Medical College	19, 21, 28, 29	D2
34	Metro General Hospital at Meharry	19, 21, 28, 29	D2
35	MTA Madison Headway	27, 86X, 96	B4
36	Municipal Auditorium	All (except 21, 72, 76)	Downtown
37	Music City Central	All (except 21, 72, 76)	Downtown
38	Music City Center (Convention Center)	12, 18, 55 BRT Blue, 93	Downtown
39	Music Valley Village	24	C4
40	Nashville State Technical Institute	3	D1
41	Opry Mills	24	C4
42	Richard H. Fulton Complex	4, 12, 18, 28, 34, 86X	D2
43	Riverfront Regional Rail Station	4, 22, 27, 34, 86X, 44, 93	Downtown
44	Rose Park Mall	26, 55X, 86 BRT Blue	A4
45	Rochelle Center	8, 17	D3
46	Ryman Auditorium	12, 18, 18, 34, 55 BRT Blue	Downtown
47	Schermerhorn Symphony Center	12, 18, 18, 34, 55 BRT Blue	Downtown
48	Shelby Park	4	D5
49	Skyline Medical Center	45	E1
50	Social Security Office (Metro Center Branch)	9	C2
51	Social Security Office (Westgate Branch)	26	A4
52	St. Thomas Hospital	3, 8	D5
53	State Capitol	All (except 21, 72, 76)	Downtown
54	State Library & Archives	All (except 21, 72, 76)	Downtown
55	Summit Medical Center	27	D5
56	Tennessee Performing Arts Center	All (except 21, 72, 76)	Downtown
57	Tennessee School for the Blind	6	D5
58	Tennessee State Fairgrounds	1, 12	D3
59	Tennessee State University	19, 21, 29	D2
60	Tennessee Titans Training Facility	9	C2
61	Trevecca Nazarene University	19, 18, 55 BRT Blue	D3
62	Union Station Hotel	3, 5, 7, 17	Downtown
63	Vanderbilt University	3, 5, 7, 15, 55X, 87X, 89X, 91X, 93X, 93	D2
64	Vanderbilt University Medical Center	7, 21, 23, 30X, 87X, 89X, 91X, 93X, 93	D2
65	Veterans Administration Hospital	7, 51, 87X, 91X, 89X, 93X, 93	D2
66	Zoo (Nashville Zoo at Grassmere)	12	E3

Park & Ride Lots

Letter	Location	Route	Grid Ref.
A	Belle Forest Park & Ride	8, 34X	A1
B	Dollar General	12, 27X	A2
C	Donelson Regional Rail Station	4, 59	C4
D	The Fellowship at Two Rivers	24	C4
E	Hermitage Regional Rail Station	4, 59	C5
F	Hickory Hollow	18, 22X, 55 BRT Blue	F2
G	Hillwood Park & Ride	18	D1
H	Hunters Lane High School Park & Ride	42	B3
I	Kmart - Goodlettsville	25X	A4
J	Kmart - Madison	26, 26, 86 BRT Blue	B3
K	Kohl's - Hendersonville	93X	A3
L	Lakewood Park & Ride	27	B5
M	Madison Square	26	B4
N	MTA Bellevue Park & Ride	8, 34X	A1
O	MTA Madison Park & Ride	27, 86X, 96	B4
P	RiverGate Park & Ride	25X	A4
Q	Smith Springs Church of Christ	28X	D5
R	Southminster Presbyterian Church	12	E3
S	Staples Park & Ride	8, 34X	A1
T	Temple Baptist Church	23	C2
U	Una Church of Christ	18	E4
V	Walmart Park & Ride	22X	F4
W	Whites Creek High School Park & Ride	42	B2



Tab 9

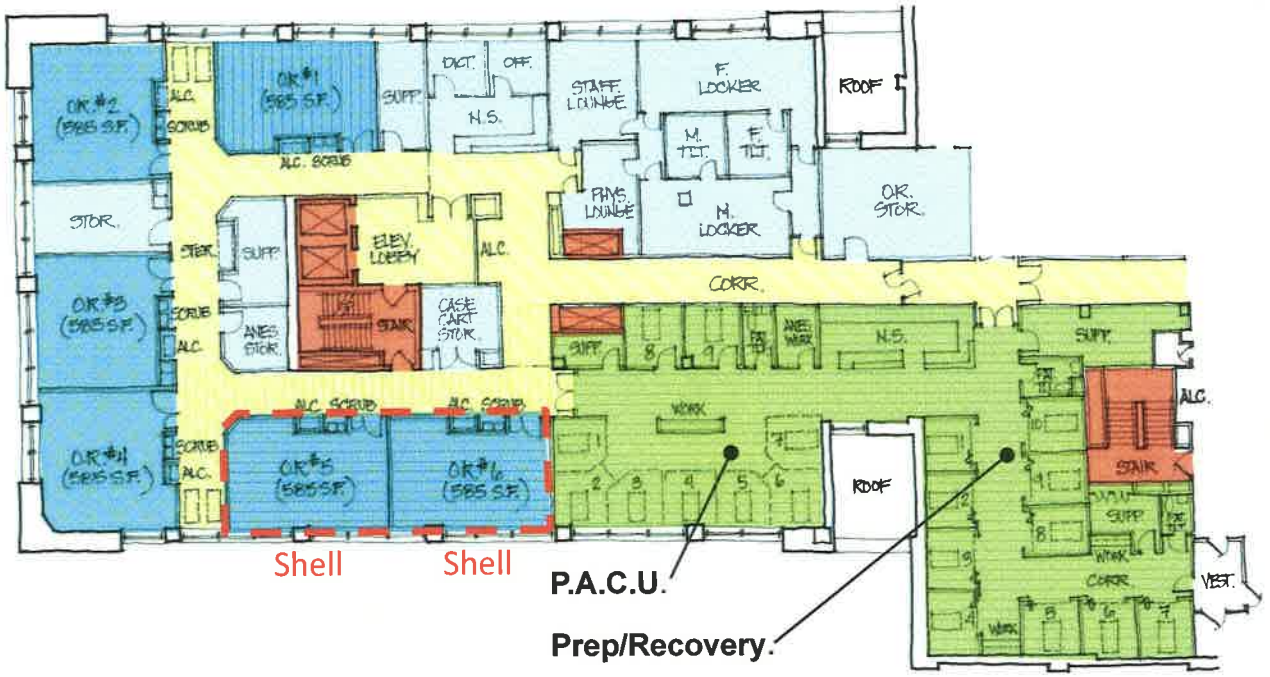
Attachment B, IV

Schematics

Baptist Hospital

A member of Saint Thomas Health

Baptist Hospital: Orthopedic/Joint Center of Excellence



2013 JUL 15 AM 10 09

Attachment C

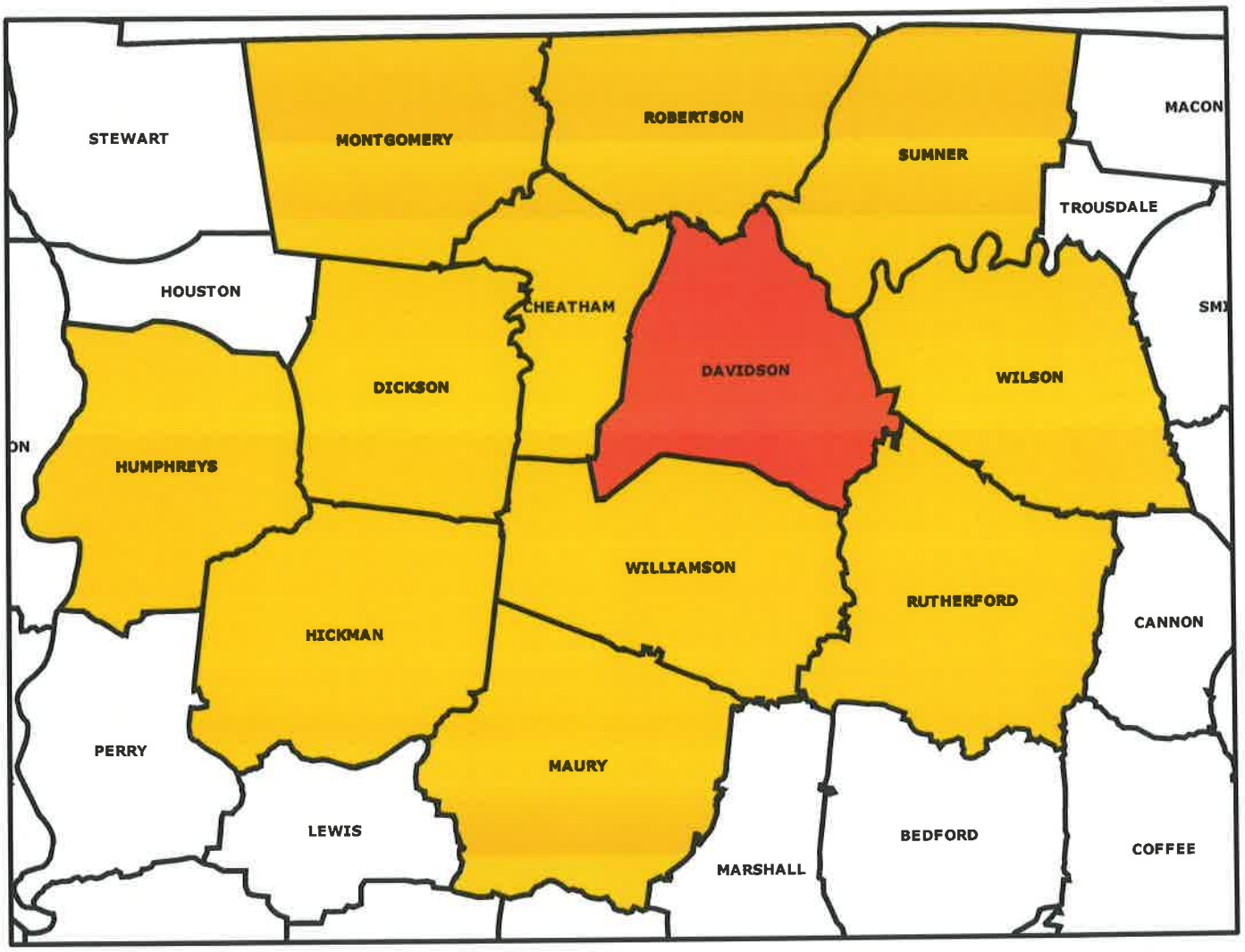
Service Area Map
TennCare Population Data
Construction Costs Verification Letter
Verification of Funding
Balance Sheet and Income Statement
Audited Financials
Letters of Support
Performance Improvement Plan
Utilization Review Plan
Patient Bill of Rights
The Joint Commission Documentation
Hospital License
Inspection Report
Plan of Corrective Action

Tab 10

Attachment C
Need - 3

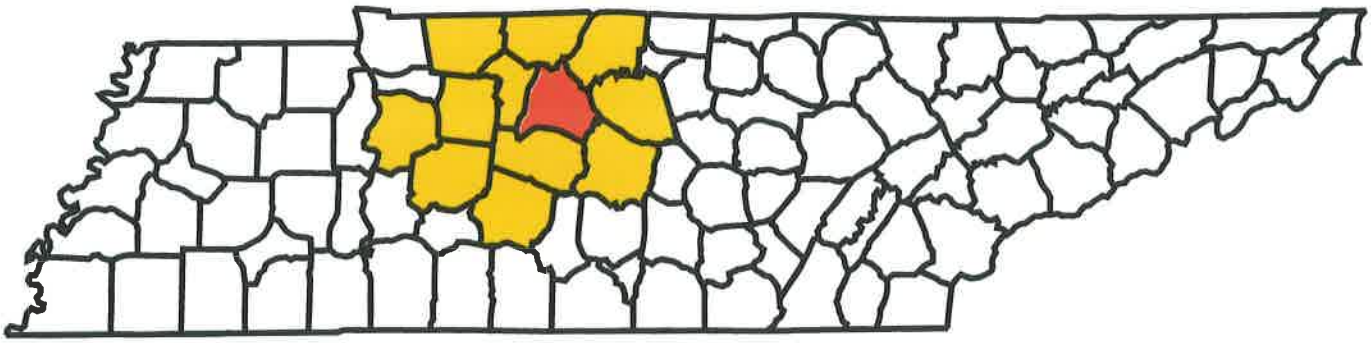
Service Area Map

Service Area Map



Primary Service Area

Secondary Service Area



Tab 11

Attachment C
Need - 4

TennCare Population Data

Service Area TennCare Population
February 2013

Service Area Counties	TennCare Enrollees	2013 Population	% Enrolled
Cheatham	6,069	39,028	15.5%
Davidson	120,067	645,722	18.6%
Dickson	8,844	50,556	17.5%
Hickman	5,398	24,053	22.4%
Humphreys	3,480	18,381	18.9%
Maury	14,601	82,133	17.8%
Montgomery	23,276	181,674	12.8%
Robertson	11,126	68,061	16.3%
Rutherford	36,376	276,375	13.2%
Sumner	22,920	167,264	13.7%
Williamson	8,557	194,928	4.4%
Wilson	14,364	119,707	12.0%
Total SA	**275,078**	**1,867,882**	**14.7%**
Tennessee	1,199,164	6,469,063	18.5%

Sources: Nielsen, Inc., Bureau of Tenncare

Tab 12

Attachment C
Economic Feasibility - 1

Construction Costs Verification Letter

Turner Healthcare

2013 JUL 15

July 9, 2013

Mr. Damian Skelton
Baptist Hospital
2000 Church Street
Nashville, TN 37236

RE: Baptist Hospital
8th Floor Orthopedic / Joint Center of Excellence
Conceptual Estimate

Mr. Skelton:

This letter is being issued as verification that the submitted estimate of cost for the proposed OR renovation project at Baptist Hospital with 17,842 SF is reasonable. The estimate of $6,054,931 is based on comparative estimates of similar construction and adjusted local trades.

I attest that the design and construction information submitted is consistent with the design and cost of similar facilities in the region. The physical environment will conform to the applicable federal, state, and local construction codes, standards, manufacturers' specifications and licensing agencies requirements, including the current 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

We hope this meets with your approval and stand ready to answer and questions that you may have. As always, we look forward to assisting in the development of this project. Please feel free to call me with any questions, clarifications, or comments.

Sincerely,
Turner Construction

W. Kevin Williams
Sr. Project Manager

CC: File

Tab 13

Attachment C
Economic Feasibility - 2

Verification of Funding

Baptist Hospital

A member of Saint Thomas Health

July 10, 2013

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Certificate of Need Application
Baptist Hospital-Replacement and relocation of four operating rooms

Dear Ms. Hill:

Baptist Hospital is applying for a Certificate of Need for the replacement and relocation renovation of four of its operating rooms. The estimated project cost is $11,499,496.

As Chief Financial Officer, I am writing to confirm that Baptist Hospital has available more than sufficient resources to fund the capital cost required to implement this project.

Thank you for your attention to this matter.

Sincerely,

Carrie Teaford
Chief Financial Officer

Tab 14

Attachment C
Economic Feasibility - 10

Balance Sheet and Income Statement

Baptist Hospital
Balance Sheet
(Dollars in Thousands)

2013 JUL 15 AM 10 09

	June 30, 2012
ASSETS:	
Cash and Investments	$ 2
Patient accounts receivable	142,705
Less allowances	(92,617)
Net Accounts Receivable	50,088
Estimated settlements from 3rd party payors	1,001
Current Portion of Assets Limited to Use	-
Inventory	3,841
Other current assets	304,282
Total Current Assets	359,214
Trusteed Assets	-
Assets Limited to Use	-
Other Long-Term Investments	-
Property, Plant, Equipment Cost	336,576
Construction in progress	8,824
Less accumulated depreciation	(242,009)
Total Property, Plant & Equipment	103,391
Investment in unconsolidated entities	947
Assets held for sale	-
Advances to affiliated entities, net	-
Other miscellaneous assets	10,556
Total Other Assets	11,503
TOTAL ASSETS	$ 474,108

	June 30, 2012
LIABILITIES:	
Current maturities of long-term debt	$ 1,932
Accounts payable	7,121
Accrued liabilities	11,109
Estimated third party payor settlement	7,013
Current portion of self-insurance liab	2,164
Other current liabilities	77,528
Total Current Liabilities	106,867
Long-term Debt	245,150
Self-insurance liability	1,236
Other non-current liabilities	5,876
Other Non-Current Liabilities	7,112
TOTAL LIABILITIES	359,129
NET ASSETS:	
Unrestricted net assets	114,979
Unrestricted net assets noncontrolling int	-
Temporarily restricted net assets	-
Permanently restricted net assets	-
TOTAL NET ASSETS	114,979
TOTAL LIAB AND NET ASSETS	$ 474,108

Baptist Hospital
Statement of Operations
For The Twelve Months Ending June 30, 2012

GROSS PATIENT SERVICE REVENUE:	
Total Inpatient Routine Revenue	$172,953,076
Inpatient Ancillary Revenue	607,385,784
Outpatient Revenue	480,037,578
Capitation Revenue	-
Total Gross Patient Service Revenue	**$1,260,376,437**
REVENUE DEDUCTIONS:	
Charity Care	$53,683,324
Medicare Deductions	330,045,831
Medicaid Deductions	123,960,550
Blue Cross Deductions	178,566,492
HMO/PPO Deductions	131,800,210
Commercial Deductions	-
Bad Debts Deductions	9,962,464
Other Revenue and Contract Deductions	41,894,114
Capitation Contra Revenue	-
Total Corrections of Est Related to PYs	-
Total Revenue Deductions	**$869,912,984**
Net Patient Service Revenue	**$390,463,453**
OTHER REVENUE:	
Other Revenue	$25,531,776
Gain on Sale of Assets	61,786
Income from Unconsolidated Entities	3,811,970
Investment Income Trust Funds	-
Net Assets Released from Restrictions	-
Total Other Revenue	**$29,405,531**
Total Operating Revenue	**$419,868,985**
OPERATING EXPENSES:	
Salaries and Wages	$107,081,196
Employee Benefits	26,898,808
Purchased Services	34,902,456
Professional Fees	10,954,966
Supplies	74,558,586
Bad Debts	-
Insurance	1,585,446
Interest	9,195,020
Income Tax	-
Depreciation	13,869,974
Amortization	2,555,138
Other Operating Expenses	104,980,915
Total Operating Expenses	**$386,582,506**
Income (Loss) From Recurring Operations	33,286,478
Investment Income SITF	-
Recurring Op Inc before Non-reucrring Items	33,286,478
Total Impair Write-Dwn, Restruct, NonRec	(10,479,327)
Income (Loss) from Operations	**$43,765,806**
NONOPERATING GAINS (LOSSES):	
Investment Income	$800
Unrealized Gain/Loss on Investments	-
Writedowns of Investments	-
Income (Loss) from Unconsolidated Entities	-
Other NonOperating Activity	175,097
Total NonOperating Gains (Losses), Net	**$175,897**
Income(Loss) Before Oth NonOper. Items	**$43,941,703**
Carondelet Contribution	-
Gain (Loss) on Early Defeasance of Debt	-
Net Income (Loss)	**$43,941,703**

Tab 15

Attachment C
Economic Feasibility - 10

Audited Financials

Consolidated Financial Statements and Supplementary Information

Ascension Health Alliance
Years Ended June 30, 2012 and 2011
With Reports of Independent Auditors

Ascension Health Alliance

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2012 and 2011

Contents

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Report of Independent Auditors

The Board of Directors
Ascension Health Alliance

We have audited the accompanying consolidated balance sheets of Ascension Health Alliance (as identified in Note 1) as of June 30, 2012 and 2011, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of Ascension Health Alliance's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of Ascension Health Alliance's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Ascension Health Alliance's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Ascension Health Alliance at June 30, 2012 and 2011, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

Ernst + Young LLP

September 12, 2012

Ascension Health Alliance

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2012	June 30, 2011
Assets		
Current assets:		
Cash and cash equivalents	**$ 306,469**	$ 1,107,846
Short-term investments	**216,914**	237,461
Accounts receivable, less allowances for uncollectible accounts ($1,145,935 and $1,079,706 at June 30, 2012 and 2011, respectively)	**1,962,549**	1,687,189
Inventories	**223,647**	190,514
Due from brokers *(see Notes 4 and 5)*	**789,271**	–
Estimated third-party payor settlements	**159,871**	89,747
Other *(see Notes 4 and 5)*	**756,216**	438,063
Total current assets	**4,414,937**	3,750,820
Long-term investments *(see Notes 4 and 5)*	**10,468,457**	8,117,951
Property and equipment, net	**6,603,603**	5,987,804
Other assets:		
Investment in unconsolidated entities	**946,971**	889,077
Capitalized software costs, net	**645,112**	486,842
Other	**696,814**	720,565
Total other assets	**2,288,897**	2,096,484
Total assets	**$ 23,775,894**	$ 19,953,059

	June 30, 2012	2011
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **45,363**	$ 29,563
Long-term debt subject to short-term remarketing arrangements*	**1,094,425**	1,662,950
Accounts payable and accrued liabilities	**2,009,229**	1,814,600
Estimated third-party payor settlements	**457,030**	276,810
Due to brokers *(see Notes 4 and 5)*	**880,613**	–
Current portion of self-insurance liabilities	**206,057**	191,551
Other *(see Notes 4 and 5)*	**435,874**	103,093
Total current liabilities	**5,128,591**	4,078,567
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**3,655,406**	2,546,785
Self-insurance liabilities	**518,995**	448,624
Pension and other postretirement liabilities	**492,366**	396,058
Other *(see Notes 4 and 5)*	**1,057,644**	676,648
Total noncurrent liabilities	**5,724,411**	4,068,115
Total liabilities	**10,853,002**	8,146,682
Net assets:		
Unrestricted		
Controlling interest	**11,836,414**	11,332,631
Noncontrolling interests	**647,236**	42,739
Unrestricted net assets	**12,483,650**	11,375,370
Temporarily restricted	**336,027**	331,563
Permanently restricted	**103,215**	99,444
Total net assets	**12,922,892**	11,806,377
Total liabilities and net assets	**$ 23,775,894**	$ 19,953,059

*Consists of variable rate demand bonds with put options that may be exercised at the option of the bondholders, with stated repayment installments through 2047, as well as certain serial mode bonds with scheduled remarketing/mandatory tender dates occurring prior to June 30, 2013. In the event that bonds are not remarketed upon the exercise of put options or the scheduled mandatory tenders, management would utilize other sources to access the necessary liquidity. Potential sources include liquidating investments, drawing upon the $1,000,000 line of credit, and issuing commercial paper. The commercial paper program is supported by the $1,000,000 line of credit, as discussed in the Long-Term Debt note.

The accompanying notes are an integral part of the consolidated financial statements.

Ascension Health Alliance

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Year Ended June 30, 2012	2011
Operating revenue:		
Net patient service revenue	**$ 15,620,035**	$ 14,565,006
Other revenue	**990,613**	841,521
Total operating revenue	**16,610,648**	15,406,527
Operating expenses:		
Salaries and wages	**6,671,985**	6,188,630
Employee benefits	**1,450,458**	1,444,867
Purchased services	**771,953**	771,836
Professional fees	**1,042,327**	889,375
Supplies	**2,309,541**	2,261,568
Insurance	**102,917**	92,168
Bad debts	**1,005,844**	991,974
Interest	**135,563**	129,014
Depreciation and amortization	**674,178**	656,859
Other	**1,827,002**	1,556,110
Total operating expenses before impairment, restructuring and nonrecurring gains (losses), net	**15,991,768**	14,982,401
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring gains (losses), net	**618,880**	424,126
Self-insurance trust fund investment return	**17,197**	90,402
Impairment, restructuring, and nonrecurring gains (losses), net	**297,548**	(92,387)
Income from operations	**933,625**	422,141
Nonoperating gains (losses):		
Investment return	**(137,383)**	1,129,859
Loss on extinguishment of debt	**(2,828)**	(1,007)
(Loss) gain on interest rate swaps	**(74,773)**	30,879
Income from unconsolidated entities	**8,802**	11,915
Contributions from business combinations	**326,333**	–
Other	**(69,510)**	(68,999)
Total nonoperating gains, net	**50,641**	1,102,647
Excess of revenues and gains over expenses and losses	**984,266**	1,524,788
Less noncontrolling interests	**15,840**	27,484
Excess of revenues and gains over expenses and losses attributable to controlling interest	**968,426**	1,497,304

Continued on next page.

Ascension Health Alliance

Consolidated Statements of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

	Year Ended June 30, 2012	2011
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	$ 968,426	$ 1,497,304
Transfers to sponsors and other affiliates, net	(19,947)	(14,495)
Contributed net assets	(400)	(374)
Net assets released from restrictions for property acquisitions	68,940	70,555
Pension and other postretirement liability adjustments	(451,555)	793,897
Change in unconsolidated entities' net assets	(15,890)	1,175
Other	9,207	(2,778)
Increase in unrestricted net assets, controlling interest, before (loss) gain from discontinued operations and cumulative effect of change in accounting principle	558,781	2,345,284
(Loss) gain from discontinued operations	(54,998)	19,421
Cumulative effect of change in accounting principle	–	(45,993)
Increase in unrestricted net assets, controlling interest	503,783	2,318,712
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	15,840	27,484
Distributions of capital	(578,445)	(33,854)
Contributions of capital	1,167,102	7,973
Increase in unrestricted net assets, noncontrolling interests	604,497	1,603
Temporarily restricted net assets, controlling interest:		
Contributions and grants	100,880	100,679
Net change in unrealized gains/losses on investments	(5,333)	15,714
Investment return	4,695	8,295
Net assets released from restrictions	(104,028)	(103,654)
Other	8,250	496
Increase in temporarily restricted net assets, controlling interest	4,464	21,530
Permanently restricted net assets, controlling interest:		
Contributions	5,082	8,030
Net change in unrealized gains/losses on investments	(25)	1,692
Investment return	(217)	(62)
Other	(1,069)	(87)
Increase in permanently restricted net assets, controlling interest	3,771	9,573
Increase in net assets	1,116,515	2,351,418
Net assets, beginning of year	11,806,377	9,454,959
Net assets, end of year	$ 12,922,892	$ 11,806,377

The accompanying notes are an integral part of the consolidated financial statements.

Ascension Health Alliance

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30, 2012	2011
Operating activities		
Increase in net assets	$ **1,116,515**	$ 2,351,418
Adjustments to reconcile increase in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	**674,178**	656,859
Amortization of bond premiums	**(10,663)**	(9,951)
Loss on extinguishment of debt	**2,828**	1,007
Provision for bad debts	**1,005,844**	991,974
Pension and other postretirement liability adjustments	**451,555**	(793,897)
Contributed net assets	**400**	374
Contributions from business combinations	**(305,162)**	–
Interest, dividends, and net losses (gains) on investments	**122,323**	(1,245,900)
Change in market value of interest rate swaps	**77,568**	(25,257)
Deferred gain on interest rate swaps	**(303)**	(303)
Gain on sale of assets, net	**(13,950)**	(21,373)
Cumulative effect of change in accounting principle	**–**	45,993
Impairment and nonrecurring expenses	**45,956**	35,384
Contribution of noncontrolling interest in CHIMCO Alpha Fund, LLC	**(440,015)**	–
Transfers to sponsor and other affiliates, net	**19,947**	14,495
Restricted contributions, investment return, and other	**(117,621)**	(117,351)
Other restricted activity	**(7,537)**	(1,393)
Nonoperating depreciation expense	**308**	311
(Increase) decrease in:		
Short-term investments	**35,298**	(9,496)
Accounts receivable	**(1,173,282)**	(1,105,326)
Inventories and other current assets	**245,684**	18,530
Due from brokers	**(83,976)**	–
Investments classified as trading	**(985,261)**	(293,254)
Other assets	**(8,752)**	(218,609)
Increase (decrease) in:		
Accounts payable and accrued liabilities	**51,319**	105,184
Estimated third-party payor settlements, net	**28,121**	53,294
Due to brokers	**(277,720)**	–
Other current liabilities	**(281,300)**	36,331
Self-insurance liabilities	**(45,390)**	(9,846)
Other noncurrent liabilities	**(365,398)**	235,877
Net cash (used in) provided by continuing operating activities	**(238,486)**	695,075
Net cash provided by (used in) and adjustments to reconcile change in net assets for discontinued operations	**107,776**	(15,718)
Net cash (used in) provided by operating activities	**(130,710)**	679,357

Continued on next page.

Ascension Health Alliance

Consolidated Statements of Cash Flows (continued)

(Dollars in Thousands)

	Year Ended June 30, 2012	2011
Investing activities		
Property, equipment, and capitalized software additions, net	$ (853,144)	$ (728,610)
Proceeds from sale of property and equipment	2,104	25,701
Net cash used in investing activities	(851,040)	(702,909)
Financing activities		
Issuance of long-term debt	1,832,269	691,240
Repayment of long-term debt	(1,779,632)	(804,536)
Decrease in assets under bond indenture agreements	17,513	467
Transfers to sponsors and other affiliates, net	(7,398)	(34,246)
Restricted contributions, investment return, and other	117,621	117,351
Net cash provided by (used in) financing activities	180,373	(29,724)
Net decrease in cash and cash equivalents	(801,377)	(53,276)
Cash and cash equivalents at beginning of year	1,107,846	1,161,122
Cash and cash equivalents at end of year	$ 306,469	$ 1,107,846

The accompanying notes are an integral part of the consolidated financial statements.

1. Organization and Mission

Organizational Structure

Ascension Health Alliance is a Missouri nonprofit corporation formed on September 13, 2011. Ascension Health Alliance is the sole corporate member and parent organization of Ascension Health, a Catholic national health system consisting primarily of nonprofit corporations that own and operate local healthcare facilities, or Health Ministries, located in 21 of the United States and the District of Columbia.

In addition to serving as the sole corporate member of Ascension Health, Ascension Health Alliance serves as the member or shareholder of various other subsidiaries, including Ascension Health Global Mission; Ascension Health Insurance, Ltd.; Edessa Insurance Company, Ltd.; the Resource Group, LLC; Clinical Holdings Corporation; Catholic Healthcare Investment Management Company (CHIMCO); Ascension Health Ventures, LLC; Ascension Health Leadership Academy, LLC; and AH Holdings, LLC. Ascension Health Alliance and its member organizations are referred to collectively as the System.

Sponsorship

Ascension Health Alliance is sponsored by Ascension Health Ministries, a Public Juridic Person. The Participating Entities of Ascension Health Ministries are the Daughters of Charity of St. Vincent de Paul in the United States, St. Louise Province, the Congregation of St. Joseph, the Congregation of the Sisters of St. Joseph of Carondelet, and the Congregation of Alexian Brothers of the Immaculate Conception Province – American Province. As more fully described in the Organizational Changes note, Alexian Brothers Health System, which was previously sponsored by the Congregation of Alexian Brothers of the Immaculate Conception Province – American Province, became part of Ascension Health on January 1, 2012.

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Health Ministries united in service and healing, and dedicates its resources to spiritually centered care which sustains and improves the health of the individuals and communities it serves. In accordance with the System's mission of service to those persons living in poverty and other vulnerable persons, each Health Ministry accepts patients regardless of their ability to pay. The

1. Organization and Mission (continued)

System uses four categories to identify the resources utilized for the care of persons living in poverty and community benefit programs:

- Traditional charity care includes the cost of services provided to persons who cannot afford healthcare because of inadequate resources and/or who are uninsured or underinsured.

- Unpaid cost of public programs, excluding Medicare, represents the unpaid cost of services provided to persons covered by public programs for persons living in poverty and other vulnerable persons.

- Cost of other programs for persons living in poverty and other vulnerable persons includes unreimbursed costs of programs intentionally designed to serve the persons living in poverty and other vulnerable persons of the community, including substance abusers, the homeless, victims of child abuse, and persons with acquired immune deficiency syndrome.

- Community benefit consists of the unreimbursed costs of community benefit programs and services for the general community, not solely for the persons living in poverty, including health promotion and education, health clinics and screenings, and medical research.

Discounts are provided to all uninsured patients, including those with the means to pay. Discounts provided to those patients who did not qualify for assistance under charity care guidelines are not included in the cost of providing care of persons living in poverty and community benefit programs. The cost of providing care to persons living in poverty and community benefit programs is estimated using each facility's internal cost data and is calculated in compliance with guidelines established by both the Catholic Health Association (CHA) and the Internal Revenue Service.

The amount of traditional charity care provided, determined on the basis of net cost, excluding the provision for bad debt expense, was $468,970 and $408,894 for the years ended June 30, 2012 and 2011, respectively. The amount of unpaid cost of public programs, cost of other programs for persons living in poverty and other vulnerable persons, and community benefit cost is reported in the accompanying supplementary information.

2. Significant Accounting Policies

Principles of Consolidation

All corporations and other entities for which operating control is exercised by Ascension Health Alliance or one of its member corporations are consolidated, and all significant inter-entity transactions have been eliminated in consolidation. Investments in entities where the System does not have operating control are recorded under the equity or cost method of accounting. Income from unconsolidated entities is included in consolidated excess of revenues and gains over expenses and losses in the accompanying Consolidated Statements of Operations and Changes in Net Assets as follows:

	Year Ended June 30, 2012	2011
Other revenue	**$ 82,473**	$ 138,469
Nonoperating gains, net	**8,802**	11,915

Use of Estimates

Management has made estimates and assumptions that affect the reported amounts of certain assets, liabilities, revenues, and expenses. Actual results could differ from those estimates.

Fair Value of Financial Instruments

Carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of other financial instruments are disclosed in the Fair Value Measurements note.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with original maturities of three months or less.

2. Significant Accounting Policies (continued)

Short-Term Investments

Short-term investments consist of investments with original maturities exceeding three months and up to one year, as well as assets limited as to use of approximately $148,000 and $146,000, at June 30, 2012 and 2011, respectively, which represent assets to be used for payment of the current portion of self-insurance liabilities.

Long-Term Investments and Investment Return

As further discussed in the Organizational Changes and Pooled Investment Fund notes, a significant portion of the System's investments historically held in the Ascension Legacy Portfolio (formerly the Health System Depository, or HSD) were transferred to the CHIMCO Alpha Fund, LLC (Alpha Fund), a limited liability company organized in the state of Delaware, in April 2012. Certain System investments continue to be held in the Ascension Legacy Portfolio. Additional System investments include those held and managed by the Health Ministries' consolidated foundations.

Investments, excluding investments in unconsolidated entities, are measured at fair value, are classified as trading securities, and include pooled short-term investment funds; U.S. government, state, municipal and agency obligations; asset-backed securities; corporate and foreign fixed income securities; and equity securities, including private equity securities. Investments also include alternative investments, including investments in hedge funds and private equity and other funds, which are valued based on the net asset value of the investments, as further discussed in the Fair Value Measurements note. Investments also include derivatives held by the Alpha Fund, also measured at fair value, as discussed in the Pooled Investment Fund note.

Long-term investments include assets limited as to use of approximately $916,000 and $848,000, at June 30, 2012 and 2011, respectively, comprised primarily of investments placed in trust and held by captive insurance companies for the payment of self-insured claims and investments which are limited as to use, as designated by donors.

Purchases and sales of investments are accounted for on a trade-date basis. Investment returns consist of dividends, interest, and gains and losses. The cost of substantially all securities sold is based on the average cost method. Investment returns on investments, excluding returns

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

of self-insurance trust funds, are reported as nonoperating gains (losses) in the Consolidated Statements of Operations and Changes in Net Assets, unless the return is restricted by donor or law. Investment returns of self-insurance trust funds are reported as a separate component of income from operations in the Consolidated Statements of Operations and Changes in Net Assets.

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market value using first-in, first-out (FIFO) or a methodology that closely approximates FIFO.

Intangible Assets

Intangible assets primarily consist of goodwill and capitalized computer software costs, including internally developed software. Costs incurred in the development and installation of internal use software are expensed or capitalized depending on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage. Intangible assets are included in the Consolidated Balance Sheets as presented in the table that follows. Capitalized software costs in the table below include software in progress of $363,347 and $199,137 at June 30, 2012 and 2011, respectively:

	June 30, 2012	2011
Goodwill	$ **126,666**	$ 118,871
Other, net	**26,688**	29,404
	153,354	148,275
Capitalized software costs	**1,216,876**	972,317
Less accumulated amortization	**571,764**	485,475
	645,112	486,842
Total intangible assets, net	$ **798,466**	$ 635,117

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

Intangible assets whose lives are indefinite, primarily goodwill, are not amortized and are evaluated for impairment at least annually, while intangible assets with definite lives, primarily capitalized computer software costs, are amortized over their expected useful lives. Amortization expense for these intangible assets in 2012 and 2011 was $90,685 and $86,490, respectively.

During the year ended June 30, 2010, the System began a significant multi-year, System-wide enterprise resource planning project, including information technology and process standardization (Symphony), which is expected to continue through December 2014. The project is anticipated to result in a transition to a common software product for various finance, information technology, procurement, and human resources management processes, including standardization of those processes throughout the System. Capitalized costs of Symphony were approximately $279,000 and $162,000 at June 30, 2012 and 2011, respectively, and are included in capitalized software costs in the preceding table. Certain costs of this project were also expensed. See the Impairment, Restructuring, and Nonrecurring Gains (Losses) discussion below for additional information about costs associated with Symphony.

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date of the gift. A summary of property and equipment at June 30, 2012 and 2011, is as follows:

	June 30, 2012	2011
Land and improvements	$ **673,292**	$ 619,465
Building and equipment	**13,107,833**	12,329,647
	13,781,125	12,949,112
Less accumulated depreciation	**7,463,388**	7,110,865
	6,317,737	5,838,247
Construction in progress	**285,866**	149,557
Total property and equipment, net	$ **6,603,603**	$ 5,987,804

Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Depreciation expense in 2012 and 2011 was $581,032 and $567,070, respectively.

2. Significant Accounting Policies (continued)

Several capital projects have remaining construction and related equipment purchase commitments of approximately $179,000.

Noncontrolling Interests

The consolidated financial statements include all assets, liabilities, revenues and expenses of entities that are controlled by the System and therefore consolidated. Noncontrolling interests in the Consolidated Balance Sheets represent the portion of net assets owned by entities outside the System, for those entities in which the System's ownership interest is less than 100%.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, which include endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donors' wishes, primarily to purchase equipment and to provide charity care and other health and educational services. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as unrestricted.

Temporarily and permanently restricted net assets consist solely of controlling interests of the System.

Performance Indicator

The performance indicator is the excess of revenues and gains over expenses and losses. Changes in unrestricted net assets that are excluded from the performance indicator primarily include pension and other postretirement liability adjustments, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, change in unconsolidated entities' net assets, cumulative effect of a change in accounting principle, discontinued operations, and contributions received of property and equipment.

2. Significant Accounting Policies (continued)

Operating and Nonoperating Activities

The System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, long-term care, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the System's primary mission are considered to be nonoperating.

Net Patient Service Revenue, Accounts Receivable, and Allowance for Uncollectible Accounts

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services provided excluding the provision for bad debt expense and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates will change by a material amount in the near term. Adjustments to revenue related to prior periods increased net patient service revenue by $149,931 and $70,973 for the years ended June 30, 2012 and 2011, respectively.

During both 2012 and 2011, approximately 36% of net patient service revenue was earned under the Medicare program and 11% under various states' Medicaid programs. The System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor arrangements. Significant concentrations of net accounts receivable at June 30, 2012 and 2011, include Medicare (20%) and various states' Medicaid programs (10%).

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

Barbara Houchin
Executive Director, Planning
Saint Thomas Midtown Hospital f/k/a Baptist Hospital
2000 Church Street
Nashville, TN 37236

RE: Certificate of Need Application CN1307-028
Saint Thomas Midtown Hospital f/k/a Baptist Hospital

Dear Ms. Houchin:

This will acknowledge our July 15, 2013 receipt of your application for a Certificate of Need for replacement and relocation of four operating rooms.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Monday, July 29, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A., Applicant Profile, Item 9**

   What is Saint Thomas Midtown Hospital's (STMH) contract status with TennCare Select?

   Is Americhoice now called UnitedHealthcare Community Plan or are the two plans different?

2. **Section B.I., Project Description**

   How will the two operating rooms on the fourth floor and two operating rooms on the seventh floor be used after completion of the proposed project?

   What is the square footage of each of the existing four operating rooms vs. the square footage of each of the proposed four operating rooms?

9. Section C, Economic Feasibility, Item 2

Please identify on the applicant's financial statements specifically the source of the cash reserves that will be utilized for the proposed project.

10. Section C, Economic Feasibility, Item 3

The applicant has stated that the cost per square foot is $339.36 including demolition and $303.21 excluding demolition; however the Square Footage Chart indicates that the cost/square foot is $259. Please address this discrepancy.

11. Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Is the Projected Data Chart for Baptist Hospital in total or just revenue and expenses specific to the 4 operating rooms?

13. Project Completion Forecast Chart

The applicant states that the project completion schedule provided reflects the anticipated schedule for the cardiac and medical imaging project. Is this a typo?

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday, September 20, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-

submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ∋ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Mark A. Farber
Deputy Director

Enclosure

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

		Year___	Year___	*Year*___
A.	Utilization Data (Specify unit of measure)	_____	_____	_____
B.	Revenue from Services to Patients			
	1. Inpatient Services	$_____	$_____	$_____
	2. Outpatient Services	_____	_____	_____
	3. Emergency Services	_____	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____	_____
	Gross Operating Revenue	$_____	$_____	$_____
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$_____	$_____	$_____
	2. Provision for Charity Care	_____	_____	_____
	3. Provisions for Bad Debt	_____	_____	_____
	Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE		$_____	$_____	$_____
D.	Operating Expenses			
	1. Salaries and Wages	$_____	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____	_____
	3. Supplies	_____	_____	_____
	4. Taxes	_____	_____	_____
	5. Depreciation	_____	_____	_____
	6. Rent	_____	_____	_____
	7. Interest, other than Capital	_____	_____	_____
	8. Management Fees:			
	a. Fees to Affiliates	_____	_____	_____
	b. Fees to Non-Affiliates	_____	_____	_____
	9. Other Expenses – Specify on separate page 12	_____	_____	_____
	Total Operating Expenses	$_____	$_____	$_____
E.	Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)		$_____	$_____	$_____
F.	Capital Expenditures			
	1. Retirement of Principal	$_____	$_____	$_____
	2. Interest	_____	_____	_____
	Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$_____	$_____	$_____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	$_____	$_____
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	$_____	$_____
NET OPERATING REVENUE		$_____	$_____
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on separate page 12	_____	_____
	Total Operating Expenses	$_____	$_____
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		$_____	$_____
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	$_____	$_____

NET OPERATING INCOME (LOSS)	$_____	$_____
LESS CAPITAL EXPENDITURES		

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

State of Tennessee
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Barbara Houchin
Executive Director, Planning
Saint Thomas Midtown Hospital f/k/a Baptist Hospital
2000 Church Street
Nashville, TN 37236

RE: Certificate of Need Application CN1307-028
Saint Thomas Midtown Hospital f/k/a Baptist Hospital

Dear Ms. Houchin:

This will acknowledge our July 15, 2013 receipt of supplemental information to your application for a Certificate of Need for replacement and relocation of four operating rooms.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Wednesday, July 31, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section C, Need, Item 6**

   In your supplemental response you state that "Although these four ORs will be used approximately 50% of the time available (2000 hours per year per operating room), initially, this represents an annual increase of 8.1%. Downsizing to three operating rooms is not an option, as Year Two utilization would rise to 68% and a fourth room would have to be added soon thereafter."

   According to Exhibit 10-Supplemental, inpatient and outpatient cases in orthopedic, joint replacement, and fracture surgeries are all expected to begin declining in 2013 and continue declining through 2016, Year 2 after project completion.

   Please discuss as your response and the data in Exhibit 10 don't seem to jive.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday, September 20, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɜ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Mark A. Farber
Deputy Director
Enclosure

ORIGINAL-

SUPPLEMENTAL-1

Saint Thomas Midtown Hosp.
F/K/A Baptist Hospital

CN1307-028

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Saint Thomas Health

2013 JUL 29 AM 10 45

July 26, 2013

Via Hand Delivery

Mark A. Farber, Deputy Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Certificate of Need Application CN1307-028
Saint Thomas Midtown Hospital f/k/a Baptist Hospital

Dear Mr. Farber:

Thank you for your letter of July 22, 2013, requesting clarification of certain items contained in our Certificate of Need application for the replacement and relocation of four operating rooms. This information is provided in triplicate, including a signed affidavit.

1. **Section A., Applicant Profile, Item 9**

   What is Saint Thomas Midtown Hospital's (STMH) contract status with TennCare Select?

   Response: Contract negotiations are currently in process with TennCare Select, with the anticipation of completing the process by the end of the year.

   Is Americhoice now called UnitedHealthcare Community Plan or are the two plans different?

   Response: Yes, AmeriChoice is now called UnitedHealthcare Community Plan. Saint Thomas Midtown Hospital has a contract as a provider in this plan.

2. **Section B.I., Project Description**

   How will the two operating rooms on the fourth floor and two operating rooms on the seventh floor be used after completion of the proposed project?

   Response: As stated on page nine of the CON application, Saint Thomas Midtown Hospital will close four existing operating rooms until such time that it determines an appropriate use of the space. In the short term, the existing space will be used for storage within the sterile OR environment.

What is the square footage of each of the existing four operating rooms vs. the square footage of each of the proposed four operating rooms?

Response: As stated on page 11 of the CON application, the existing four operating rooms are 333, 333, 510 and 510 square feet. The proposed four operating rooms will be 585 square feet each.

What is the current total complement of operating and procedure rooms at STMH and what will that complement be after project completion? What is the breakdown of operating rooms and procedure rooms by floor?

Response: The current total complement of operating and procedure rooms at STMH is 26 operating rooms (including 2 cysto/litho rooms and 1 endovascular suite) and 5 procedure rooms (endoscopy). There will be no change after project completion – 26 operating rooms and 5 procedure rooms.

The breakdown of operating rooms and procedure rooms by floor is as follows.

	Existing		Proposed	
	ORs	Proc Rms	ORs	Proc Rms
4th Floor	17		15	
7th Floor	9		7	
8th Floor		5	4	5
Total	26	5	26	5

Please note that cardiac catheterization and electrophysiology labs are excluded from these totals.

3. Section B.II.A., Project Description

Do any of STMH's current operating rooms contain 585 or more square feet? If yes, how many are there and what types of surgeries are performed there?

Response: Yes, of the 26 operating rooms at STMH, only 4 have more than 585 square feet.

OR	SF	Types of Surgeries
#19	597	Heart Room – CABG, Thoracotomies
#12	601	Cranial (neuro), Spine (ortho/neuro)
#7	606	Cranial (neuro)
#18	612	Heart Room – CABG, Thoracotomies

Are the shelled-in operating rooms included in the Square Footage Chart?

Response: Yes, the shelled-in operating rooms are included in the Square Footage Chart.

4. Section B. III., Project Description (Plot Plan)

Please submit a revised plot plan that identifies where the proposed orthopedic suite will be located on the STMH campus.

Response: A revised plot plan is provided in **Attachment A**. The proposed orthopedic suite will be located above the 21st Avenue patient entrance section of the campus.

5. Section B. IV., Project Description, Floor Plan

What other services will be provided on the eighth floor? Where is central sterile supply and how will the proposed project impact the efficiency and effectiveness of supply flow?

Response: Joint replacement inpatient beds already are located on the eighth floor, thus making this floor a logical location for the placement of the proposed orthopedic surgical suite and related support space. In addition, five endoscopic procedure rooms are on this floor.

Central sterile supply is located on the second floor, where there are no operating rooms. In the future, STMH will evaluate the feasibility of moving central sterile supply to the eighth floor as well in order to reduce supply delivery and processing times. In the meantime, STMH staff and surgeons are working to streamline supply delivery and processing times.

6. Section C Item 1.a. (Service Specific Criteria-Construction, Renovation, etc.)

Your response to this item is noted. Please provide a response to the applicable criteria and standards found on Page 23 of the Guidelines for Growth, 2000.

Response: These criteria and standards are addressed below.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   Response: Not applicable. The STMH project does not include the addition of beds, services or medical equipment.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response: Not applicable. The STMH operating room project does not include the relocation or replacement of an existing licensed health care institution.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

Response: As indicated on pages 26 and 27 of the original CON application, STMH (f/k/a Baptist Hospital) provides a wide range of surgical services, including orthopedic surgery services, and it will continue to do so in the future. Today, Baptist Hospital operates 26 operating rooms, including 2 dedicated cardiac operating rooms.[1] Over the past five years (2008 to 2012), the hospital has accounted for, on average, almost 16,500 surgical encounters.

Baptist Hospital's orthopedic surgery program is a comprehensive service line that has received regional recognition for its quality and overall excellence. Its orthopedic program is ranked number one in Tennessee and among the top five for orthopedics nationally. Baptist Hospital is currently the provider of choice for the Tennessee Titans football team. The service line includes services for the foot and ankle, joint replacement, sports medicine, hand and upper extremity, general orthopedics, spine, and rehabilitation. From 2008 to 2012, Baptist Hospital's orthopedic surgery program accounted for over 2,800 patient encounters annually.

Baptist Hospital's joint replacement program is especially strong, led by a team of joint replacement specialists including surgeons, orthopedic certified nurses, patient care technicians, case managers and physical therapists. Baptist Hospital performs almost 1,450 joint replacements annually, which account for approximately 50% of its total orthopedic surgery volume. The hospital's orthopedic surgeons have historically been leaders and innovators in joint replacement, having developed some of the first implants and surgical protocols. In addition, Baptist Hospital orthopedic surgeons have been active participants in research programs and the design of new technology for joint replacement. Joint replacement services include procedures for shoulder replacements, hip replacements and knee replacements. Baptist Hospital also provides free public seminars on a range of topics related to joint pain. In addition, the hospital's orthopedic surgery program performs surgeries on between 400 and 500 fracture cases annually. **Attachment B** profiles Baptist Hospital's surgical volumes over the past five years.

[1] 2008 - 2012 ASTC JAR references to 26 inpatient operating rooms plus either 2 outpatient or 2 cardiac operating rooms are incorrect. The correct description should be 26 operating rooms *including* 2 dedicated open heart operating rooms (and 0 dedicated outpatient operating rooms).

The intent of the project is to consolidate and expand four orthopedic operating rooms that the hospital uses primarily for joint replacement and fracture surgery, which are located in multiple locations in the hospital. Baptist Hospital will consolidate these four existing orthopedic operating rooms in an orthopedic surgical suite with dedicated PACU and Prep/Recovery. In addition, inpatient orthopedic surgical patients will be cared for on an adjacent inpatient unit, furthering Baptist Hospital's goal of improving patient flow and care coordination by creating a "single floor" experience. Baptist Hospital expects that it will achieve operational efficiencies and quality enhancements from this project.

Because of recent trends of flat and some decline in joint replacement volumes, Baptist Hospital conservatively projects that it will perform 1,417 joint replacement and fracture surgical cases in its eighth floor orthopedic surgery suite in Year 1 (FY2015) and 1,487 surgical cases in Year 2 (FY2016).

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Response: As indicated on page 26 of the original CON application, the intent of the project is to consolidate and expand four orthopedic operating rooms that the hospital uses primarily for joint replacement and fracture surgery, which are located in multiple locations in the hospital. Baptist Hospital will consolidate these four existing orthopedic operating rooms in an orthopedic surgical suite with dedicated PACU and Prep/Recovery. In addition, inpatient orthopedic surgical patients will be cared for on an adjacent inpatient unit, furthering Baptist Hospital's goal of improving patient flow and care coordination by creating a "single floor" experience. Baptist Hospital expects that it will achieve operational efficiencies and quality enhancements from this project.

As indicated on page 38 of the original CON application, STMH (f/k/a Baptist Hospital) anticipates improved operational efficiencies, larger operating rooms with the capability to perform complex surgical procedures and quality enhancements after implementing its proposal to consolidate and expand four of its orthopedic operating rooms. These specific goals are consistent with Baptist Hospital's overall goals. As discussed, the existing orthopedic operating rooms are not centrally located and are undersized and unable to accommodate the imaging equipment and larger operating tables needed for complex orthopedic cases. As with most medical/surgical hospitals, orthopedic surgery is a key service line for Baptist Hospital and one of the core services that it offers. The current arrangement of orthopedic operating rooms limits the types of procedures that the hospital's surgeons can perform, creates poor patient flows, limits staff productivity and creates physician dissatisfaction with the service line's facilities.

Although studied, Baptist Hospital did not consider renovating and enlarging the existing operating rooms in their current locations to be a viable option. First, renovation of the existing operating rooms would require Baptist Hospital to interrupt operations of these rooms, which would limit the hospital's surgical capacity and disrupt services. To accommodate the expansion of its orthopedic operating rooms, Baptist

Hospital would have to expand into areas adjacent to the existing operating rooms, which was not desirable. In addition, enlarging the existing operating rooms would not address the operational issues that currently exist by not having the four orthopedic operating rooms located in the same area.

Although new construction of an orthopedic surgery suite was an option, Baptist Hospital considered the proposed project to be a superior plan. Baptist Hospital anticipated the cost of new construction to be higher than the costs of the proposed project. In addition, new construction would not allow the orthopedic surgery suite to be contiguous to an inpatient unit thereby allowing Baptist Hospital to create a single floor experience for its orthopedic patients and gain the advantage of improved staff communication and care coordination that comes from the surgical suite and inpatient unit being on the same floor and contiguous.

Baptist Hospital's proposal to renovate the eighth floor to accommodate an orthopedic surgery suit is the most responsible plan for addressing the current facility limitations of the orthopedic surgical service. The project addresses all of the deficiencies of Baptist Hospital's existing orthopedic operating rooms and does so in a cost-effective approach.

7. Section C, Need, Item 4

Is it correct that the median household income in the primary and secondary service area is expected to decline between 2013 and 2018?

Response: Median household income data were obtained from Nielsen (f/k/a Claritas). Nielsen presents itself as a leading global information and measurement company, providing market research and data to, among others, Fortune 500 corporations. Nielsen demographic data are widely accepted in the healthcare industry.

Median household income data were verified. No discrepancies were found from the source reports to the CON application. In addition, trends in average household income follow the same patterns as median household income. Nielsen was contacted for clarification of their methodology and results. A response is still pending.

Please note that of the 15 geographic areas examined in Exhibit 7 (page 23) of the original CON application, 4 actually project an increase in median household income – Hickman County, Montgomery County, Williamson County and United States overall.

As a possible alternative, the Tennessee Department of Revenue website was consulted. No income projections were provided. However, a link to University of Tennessee Knoxville economic forecasts through 2014 did suggest income growth statewide. See http://cber.bus.utk.edu/tefs/spr13.pdf, PDF page 19.

Regardless of the projected trend in income, STMH's proposed project is not significantly dependent upon income projections.

8. Section C, Need, Item 6

Does the applicant expect to only perform joint replacement and fracture surgery in the four new operating rooms? If yes, is it correct to assume that the four enlarged operating rooms will have an average patient volume of approximately 474 encounters per room annually?

Response: As indicated on pages 26 and 27 of the original CON application, the intent of the project is to consolidate and expand four orthopedic operating rooms that the hospital uses primarily for joint replacement and fracture surgery. It is possible that shoulder scope procedures might also benefit from the larger operating rooms, which allow greater space for more complex cases requiring support equipment.

What is the average time required to complete encounters in these four rooms including time for cleanup and preparation between encounters? What percentage of available operating time will these 4 ORs utilize during each of the first two years of operation?

Response: The average time required to complete encounters in these four rooms, including time for cleanup and preparation between encounters, is 166 minutes for joint replacement surgery and 158 minutes for fracture surgery. As indicated on pages 26 and 27 of the original CON application, these types of cases are conservatively estimated at 1,417 in Year One and 1,487 in Year Two. At approximately 165 minutes per encounter, 945 hours of operating room time per OR will be used in Year One and 1,022 hours in Year Two.

Although these four ORs will be used approximately 50% of the time available (2,000 hours per year per operating room), initially, this represents an annual increase of 8.1%. Downsizing to three operating rooms is not an option, as Year Two utilization would rise to 68% and a fourth room would have to be added soon thereafter.

Please expand Exhibit 10 through 2016 and provide a breakout between inpatient and outpatient surgery.

Response: An expanded Exhibit 10 with a breakout between inpatient and outpatient surgery is provided in **Attachment B**.

9. Section C, Economic Feasibility, Item 2

Please identify on the applicant's financial statements specifically the source of the cash reserves that will be utilized for the proposed project.

Response: A letter from the CFO of Saint Thomas Health explains the centralized cash management of all Saint Thomas Hospitals and provides a June 2013 balance sheet for Nashville ministry system. Please refer to the documentation provided in **Attachment C**.

10. Section C, Economic Feasibility, Item 3

The applicant has stated that the cost per square foot is $339.36 including demolition and $303.21 excluding demolition; however the Square Footage Chart indicates that the cost/square foot is $259. Please address this discrepancy.

Response: All the cost per square foot amounts cited above are correct. The $339.36 and $303.21 include a construction contingency (separate from an owner's contingency) as well as fully allocated penthouse costs for electrical and mechanical systems. In contrast, the $259 does not include demolition costs or the fully allocated penthouse costs for electrical and mechanical systems.

Please note that in comparison to other hospital renovation projects, operating room space represents one of the most expensive to be undertaken on a cost per square foot basis. Additionally, many other projects involve less complex and costly renovation of shell space. This project involves the renovation of an existing patient care area to operating room space.

11. Section C., Economic Feasibility, Item 4 (Historical and Projected DataCharts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Response: Please refer to the more detailed Historical and Projected Data Charts provided in **Attachment D**. This project does not involve management fees, either to affiliates or non-affiliates.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Is the Projected Data Chart for Baptist Hospital in total or just revenue and expenses specific to the 4 operating rooms?

Response: The projected Data Chart for Baptist Hospital is presented in total for the entire hospital (it is a hospital-wide pro forma).

13. Project Completion Forecast Chart

The applicant states that the project completion schedule provided reflects the anticipated schedule for the cardiac and medical imaging project. Is this a typo?

Response: Yes, references to "cardiac and medical imaging" are a typo. The correct text reference is "operating room." These typos occur on two pages, the project completion schedule referenced above (page 47) and the project description (page 7). Corrected pages are provided in **Attachment E**.

In preparing these supplemental responses, it was found that Exhibits 8 and 9 in the CON application contained duplicate entries in one year for Southern Hills Medical Center and Summit Medical Center. A corrected page 25 is provided in **Attachment F**. This correction does not have a material impact on the analyses or need for this project. Exhibits 8 and 9 were provided for comparison purposes only.

A signed affidavit is provided in **Attachment G**.

On behalf of Saint Thomas Midtown Hospital f/k/a Baptist Hospital and the entire Saint Thomas Health system, thank you for the opportunity to present our case for the upgrade of highly complex orthopedic joint replacement and fracture surgery services.

Sincerely,

Barbara Houchin
Executive Director, Planning

Attachments

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment A

SUPPLEMENTAL- # 1

July 29, 2013

Baptist Hospital

A Member of Saint Thomas Health Services

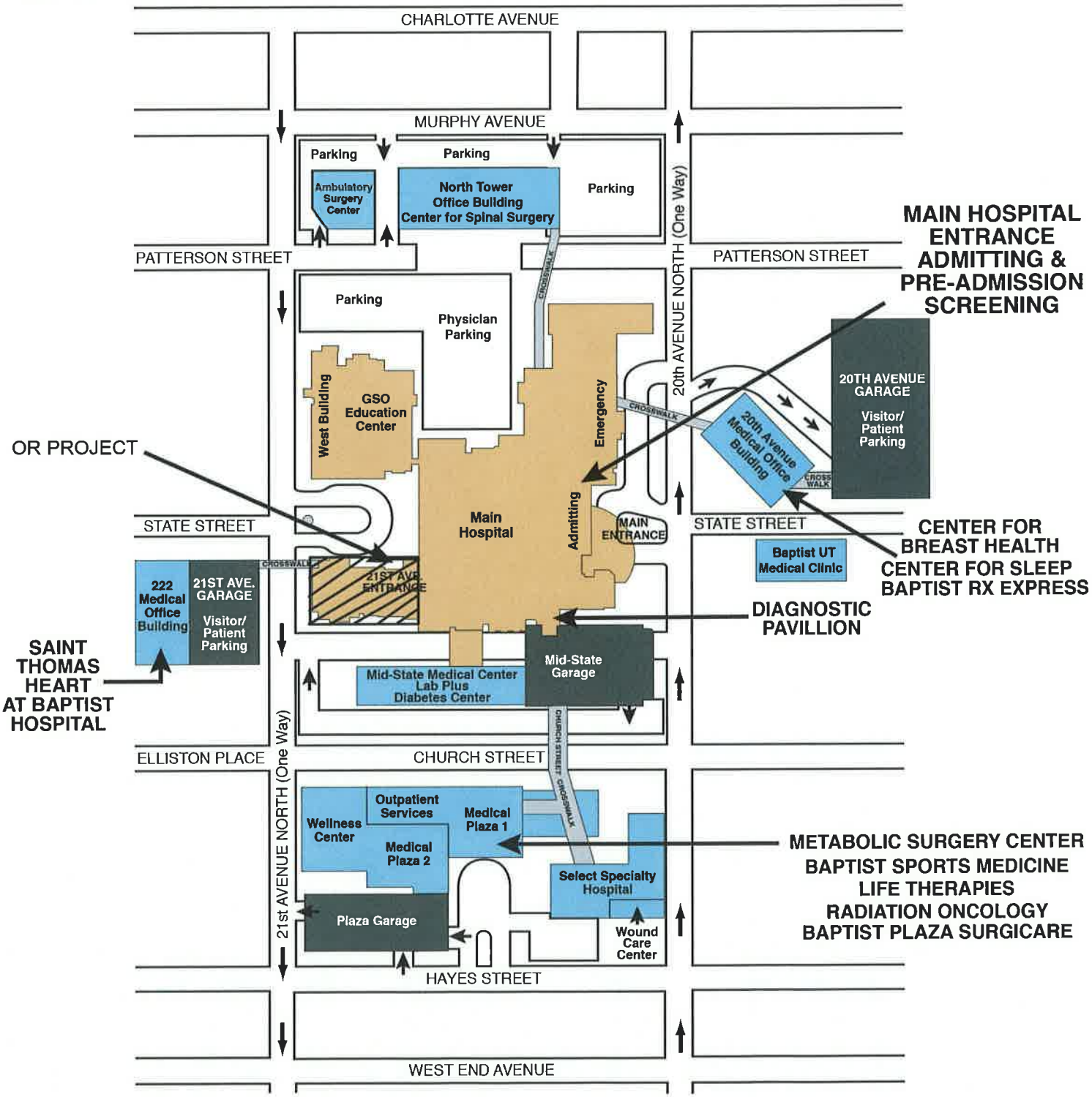
Campus Map

2000 Church Street, Nashville, Tennessee 37236
(615) 284-5555 • www.BaptistHospital.com

2013 JUL 29 AM 10 45

Patient Information (615) 284-5288

Baptist Hospital is a tobacco free campus.



Free parking is available for patients and visitors in the 21st Avenue, 20th Avenue and Plaza parking garages. The Mid-State Garage offers free parking for Mid-State Medical Center, obstetrics, joint replacement center and cardiovascular lab patients only (no visitor parking). Free valet parking is available Monday to Friday from 6 a.m. to 4 p.m. at the 20th Avenue Main Entrance to the hospital.

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment B

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Exhibit 10 - Supplemental
Baptist Hospital Surgical Trends and Utilization, 2008 - 2016 (Cases)

Inpatient & Outpatient	Historical						Interim		Year 1	Year 2
	2008	2009	2010	2011	2012	Average	2013	2014	2015	2016
Total Surgery	17,444	17,062	14,544	16,988	16,415	16,491	15,312	15,025	14,744	14,476
Orthopedic Surgery	2,846	3,024	2,809	2,714	2,738	2,826	2,465	2,394	2,326	2,261
Joint Replacement Surgery	1,421	1,485	1,436	1,419	1,402	1,433	1,429	1,443	1,349	1,310
Fracture Surgery	496	513	458	415	435	463	382	367	353	341

Inpatient Only	Historical						Interim		Year 1	Year 2
	2008	2009	2010	2011	2012	Average	2013	2014	2015	2016
Total Surgery	9,529	9,008	6,253	9,387	9,526	8,741	9,047	8,929	8,812	8,696
Orthopedic Surgery	2,111	2,141	2,078	2,070	2,110	2,102	1,957	1,917	1,878	1,839
Joint Replacement Surgery	1,391	1,446	1,398	1,381	1,359	1,395	1,395	1,413	1,321	1,285
Fracture Surgery	275	265	252	233	241	253	226	222	218	215

Outpatient Only	Historical						Interim		Year 1	Year 2
	2008	2009	2010	2011	2012	Average	2013	2014	2015	2016
Total Surgery	7,915	8,054	8,291	7,601	6,889	7,750	6,265	6,096	5,932	5,780
Orthopedic Surgery	735	883	731	644	628	724	508	478	449	422
Joint Replacement Surgery	30	39	38	38	43	38	34	30	28	25
Fracture Surgery	221	248	206	182	194	210	156	145	135	126

Sources: Joint Annual Reports and Baptist Hospital Internal Data

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment C

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Saint Thomas Health

July 24, 2013

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Certificate of Need Application CN1307-028
Saint Thomas Midtown Hospital f/k/a Baptist Hospital

Dear Ms. Hill:

Saint Thomas Health has a centralized cash management program for managing and investing operating funds for all Saint Thomas Health hospitals, including Saint Thomas Midtown Hospital. This letter is to confirm that Saint Thomas Health has available more than sufficient resources to fund the projected cost of $11,499,496 required to implement Midtown Hospital's project to replace and relocate four of its operating rooms.

As indicated in the attached June 30, 2013 Balance Sheet for Saint Thomas Health, the ministry has available $618 million in cash and equivalents ($13 million current cash and investments plus $605 million other long-term investments).

Thank you for your attention to this matter.

Sincerely,

Craig Polkow
Chief Financial Officer

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

Saint Thomas Health

Saint Thomas Health
Consolidated Balance Sheet
As of June 30, 2013
(Dollars in Thousands)

	June 30, 2013
ASSETS:	
Cash and investments	$ 12,647
Patient accounts receivable	417,372
Less allowances	(278,816)
Net accounts receivable	138,556
Estimated settlements from 3rd party payors	7,637
Current portion of assets limited to use	502
Inventory	15,816
Other current assets	25,858
Total Current Assets	201,016
Trusteed assets	30,239
Assets Limited to Use	30,239
Other Long-Term Investments	605,467
Property, plant, equipment cost	1,160,253
Construction in progress	32,668
Less accumulated depreciation	(724,421)
Total Property, Plant & Equipment	468,500
Investment in unconsolidated entities	36,252
Assets held for sale	-
Advances to affiliated entities, net	2
Other miscellaneous assets	71,252
Total Other Assets	107,506
TOTAL ASSETS	$ 1,412,728

	June 30, 2013
LIABILITIES:	
Current maturities of long-term debt	$ 6,400
Accounts payable	34,912
Accrued liabilities	45,398
Estimated third party payor settlement	16,585
Current portion of self-insurance liability	10,023
Other current liabilities	34,092
Total Current Liabilities	147,410
Long-term Debt	407,177
Self-insurance liability	3,069
Other non-current liabilities	29,262
Other Non-Current Liabilities	32,331
TOTAL LIABILITIES	586,918
NET ASSETS:	
Unrestricted net assets	792,910
Unrestricted net assets noncontrolling interest	2,158
Temporarily restricted net assets	28,455
Permanently restricted net assets	2,287
TOTAL NET ASSETS	825,810
TOTAL LIABILITES AND NET ASSETS	$ 1,412,728

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment D

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Dollars reported in thousands)

		Year 2011	Year 2012	Year 2013
A.	Utilization Data (Patient Days)	113,135	112,163	108,732
B.	Revenue from Services to Patients			
1.	Inpatient Services	$690,544	$780,339	$862,034
2.	Outpatient Services	371,468	408,992	399,432
3.	Emergency Services	64,527	71,046	69,385
4.	Other Operating Revenue (Specify)_____	15,775	29,405	27,821
	Gross Operating Revenue	**1,142,315**	**1,289,782**	**1,358,672**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	715,893	806,267	883,666
2.	Provision for Charity Care	24,972	53,683	36,117
3.	Provisions for Bad Debt	14,368	9,962	21,308
	Total Deductions	**755,234**	**869,913**	**941,090**
NET OPERATING REVENUE		387,081	419,869	417,582
D.	Operating Expenses			
1.	Salaries and Wages	135,028	133,380	127,496
2.	Physician's Salaries and Wages	0	0	0
3.	Supplies	68,938	74,598	77,106
4.	Taxes	0	0	0
5.	Depreciation	17,371	16,425	16,627
6.	Rent	0	0	0
7.	Interest, other than Capital	9,899	9,195	8,524
8.	Management Fees:			
a.	Fees to Affiliates	0	0	0
b.	Fees to Non-Affiliates	0	0	0
9.	Other Expenses – Specify on separate page 12	135,304	152,984	150,771
	Total Operating Expenses	**366,539**	**386,582**	**380,524**
E.	Other Revenue (Expenses) – Net (Specify)_____	285	0	0
NET OPERATING INCOME (LOSS)		20,827	33,286	37,058
F.	Capital Expenditures			
1.	Retirement of Principal	$_____	$_____	$_____
2.	Interest	_____	_____	_____
	Total Capital Expenditures	**0**	**0**	**0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$20,827**	**$33,286**	**$37,058**

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July. (Dollars reported in thousands)

2013 JUL 29 AM 10:46

		Year 2015	Year 2016
A.	Utilization Data (Patient Days)	106,291	105,228
B.	Revenue from Services to Patients		
1.	Inpatient Services	$956,317	$1,026,480
2.	Outpatient Services	449,483	477,448
3.	Emergency Services	78,079	82,937
4.	Other Operating Revenue (Specify)_____	24,408	24,089
	Gross Operating Revenue	**1,508,287**	**1,610,954**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	1,006,066	1,091,858
2.	Provision for Charity Care	38,611	41,291
3.	Provisions for Bad Debt	28,339	30,306
	Total Deductions	**1,073,016**	**1,163,455**
NET OPERATING REVENUE		435,271	447,499
D.	Operating Expenses		
1.	Salaries and Wages	139,666	145,534
2.	Physician's Salaries and Wages	0	0
3.	Supplies	74,711	76,538
4.	Taxes	0	0
5.	Depreciation	18,071	18,288
6.	Rent	0	0
7.	Interest, other than Capital	9,539	9,367
8.	Management Fees:		
	a. Fees to Affiliates	0	0
	b. Fees to Non-Affiliates	0	0
9.	Other Expenses – Specify on separate page 12	160,310	163,579
	Total Operating Expenses	**402,297**	**413,306**
E.	Other Revenue (Expenses) -- Net (Specify)_____	0	0
NET OPERATING INCOME (LOSS)		32,974	34,193
F.	Capital Expenditures		
1.	Retirement of Principal	$_____	$_____
2.	Interest	_____	_____
	Total Capital Expenditures	**$0**	**$0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$32,974**	**$34,193**

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2011	Year 2012	Year 2013
1. Purchased Services	$30,868	$34,902	$34,181
2. Professional Fees	9,689	10,955	9,588
3. Miscellaneous	94,747	107,127	107,002
4.			
5.			
6.			
7.			
Total Other Expenses	**$135,304**	**$152,984**	**$150,771**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2015	Year 2016
1. Purchased Services	$33,812	$34,826
2. Professional Fees	9,906	10,043
3. Miscellaneous	116,592	118,710
4.		
5.		
6.		
7.		
Total Other Expenses	**$160,310**	**$163,579**

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment E

ORTHOPEDIC OPERATING ROOMS (4)
CONSOLIDATION, RELOCATION AND EXPANSION (RESIZING)

APPLICANT OVERVIEW: For more than 90 years, Baptist Hospital has been devoted to physical, emotional and spiritual healing. Baptist Hospital is the largest not-for-profit community hospital in Middle Tennessee, licensed for 683 acute and rehab care beds. Baptist Hospital's heritage of healing is one of continuous growth, community service and superior care. Recent achievements in clinical care include:

- Nation's 100 Top Hospitals by Thomson Reuters and 100 Top Hospitals Everest Award
- 2010 HealthGrades Hospital Quality in America Study – selected results for cardiac care
  - Five-star rated for Coronary Bypass Surgery
  - Ranked among the top 3 hospitals in Tennessee for Cardiac Surgery
  - Ranked among the top 5 hospitals in Tennessee for Overall Cardiac Care
  - Ranked best in Nashville for Overall Cardiac Care
- Three-Year Approval with Commendation from the Commission on Cancer of the American College of Surgeons
- Accredited by the American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC) - First in Middle Tennessee
- Certification Mark for ACR Breast Imaging Centers of Excellence (BICOE)

PROPOSED SERVICES AND EQUIPMENT: Baptist Hospital is not proposing any new services or CON reviewable equipment. As described more fully in the need section below, this project involves the consolidation, relocation and expansion of four existing orthopedic operating rooms into an orthopedic surgery suite. To stage the project, it will be necessary to renovate an existing nursing floor of the hospital, located on the eighth floor. Baptist Hospital will redistribute the displaced beds on the nursing floor throughout the hospital and, therefore, the hospital's licensed bed capacity will not change. The project includes renovation of approximately 17,842 square feet, which will consolidate four of Baptist Hospital's orthopedic operating rooms into an orthopedic surgery suite with dedicated PACU and Prep/Recovery area.

OWNERSHIP STRUCTURE: Baptist Hospital, owned by Seton Corporation, is a member of Nashville-based Saint Thomas Health, which is part of Ascension Health. Ascension Health is a Catholic organization that is the largest not-for-profit health system in the United States. Other members of Saint Thomas Health include Saint Thomas Hospital in Nashville, Middle Tennessee Medical Center in Murfreesboro and Hickman Community Hospital in Centerville. The proposed project will not result in a change in ownership structure.

SERVICE AREA: Based on historical patient origin data, Baptist Hospital's service area for this project is comprised of 12 counties in Middle Tennessee. As reported in the hospital's FY2012 patient origin data, this 12-county area represents 89.5% of Baptist Hospital's inpatient discharges.

Cheatham	Humphreys	Rutherford
Davidson	Maury	Sumner
Dickson	Montgomery	Williamson
Hickman	Robertson	Wilson

NEED: Baptist Hospital needs to consolidate and expand its orthopedic operating rooms to improve operational efficiency, provide rooms that are large enough to accommodate imaging equipment and larger operating table, and enhance the overall quality of orthopedic surgery services. Achieving these objectives was instrumental in Baptist Hospital's decision to proceed with this project.

- Improve patient flow and operational efficiency: The orthopedic operating rooms are not centrally located, which creates poor patient flow and operational inefficiencies. Four of Baptist Hospital's orthopedic operating rooms, which the hospital primarily utilizes for joint replacement and fracture surgeries, are located on the fourth floor (two operating rooms) and seventh floor (two

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see **Attachment D – Proof of Publication (Tabs 24-25).**

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   RESPONSE: The project completion schedule below reflects the anticipated schedule for the operating room project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment F

Exhibit 8
Top Service Area Orthopedic Surgery Providers
Surgical Trends, Total Surgeries, 2009 – 2011

	Inpatient								
	2009			2010			2011		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	26	9,008	24,852	26	6,253	21,268	26	9,387	22,875
Centennial Med Ctr	33	8,690	12,733	33	7,131	9,939	37	7,377	10,964
Saint Thomas Hospital	18	7,857	24,554	18	7,624	27,175	18	7,662	25,978
Skyline Med Ctr	12	2,393	0	12	2,266	0	12	2,113	2,141
Southern Hills Med Ctr	10	1,148	1,408	10	969	1,246	10	883	1,068
Summit Med Ctr	10	1,962	2,138	0	1,988	2,195	12	2,455	2,611
Vanderbilt Uni Hosp	54	21,283	40,462	61	21,633	43,346	62	22,242	46,436
	Outpatient								
	2009			2010			2011		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	0	8,054	14,023	0	8,291	15,129	2	7,601	14,319
Centennial Med Ctr	4	11,571	17,845	4	3,858	4,566	0	10,817	16,456
Saint Thomas Hospital	2	2,885	5,360	2	3,084	5,852	2	3,580	6,574
Skyline Med Ctr	0	3,081	0	0	2,906	0	0	2,769	2,748
Southern Hills Med Ctr	10	2,662	4,318	10	2,344	4,692	10	2,275	2,657
Summit Med Ctr	0	3,797	4,299	0	3,515	4,167	0	2,932	3,525
Vanderbilt Uni Hosp	3	18,597	30,627	6	23,674	39,399	5	25,631	43,705

Source: Tennessee Joint Annual Reports, 2009 - 2011

Exhibit 9
Inpatient and Outpatient Surgical Utilization per Operating Room
Surgical Trends, Total Surgeries, 2009 – 2011

	Inpatient and Outpatient Utilization per OR								
	2009			2010			2011		
Facility	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR
Baptist Hospital	26	656	1,495	26	559	1,400	28	607	1,328
Centennial Med Ctr	37	548	826	37	297	392	37	492	741
Saint Thomas Hospital	20	537	1,496	20	535	1,651	20	562	1,628
Skyline Med Ctr	12	456	0	12	431	0	12	407	407
Southern Hills Med Ctr	20	191	286	20	166	297	20	158	186
Summit Med Ctr	10	576	644	0	N/A	N/A	12	449	511
Vanderbilt Uni Hosp	57	700	1,247	67	676	1,235	67	715	1,345

Source: Tennessee Joint Annual Reports, 2009 - 2011

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

Attachment G

SUPPLEMENTAL- # 1
July 29, 2013
10:50am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

2013 JUL 29 AM 10 46

NAME OF FACILITY: Saint Thomas Midtown Hospital f/k/a Baptist Hospital

I, BARBARA HOUCHIN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Barbara Houchin / Executive Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 26 day of July, 2013, witness my hand at office in the County of DAVIDSON, State of Tennessee.

Diane Franklin
NOTARY PUBLIC

My commission expires 01/04, 2014.

HF-0043

Revised 7/02

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.

Copy
Supplemental #2

St. Thomas Midtown Hospital

CN1307-028

SUPPLEMENTAL- # 2
July 31, 2013
10:41 am

Saint Thomas Health

2013 JUL 31 AM 10 37

July 31, 2013

Via Hand Delivery

Mark A. Farber, Deputy Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Certificate of Need Application CN1307-028
Saint Thomas Midtown Hospital f/k/a Baptist Hospital

Dear Mr. Farber:

Thank you for your letter of July 29, 2013, acknowledging receipt of our supplemental information and requesting clarification on one item pertaining to our Certificate of Need application for the replacement and relocation of four operating rooms. This response is provided in triplicate, including a signed affidavit.

1. **Section C, Need, Item 6**

   In your supplemental response you state that "Although these four ORs will be used approximately 50% of the time available (2000 hours per year per operating room), initially, this represents an annual increase of 8.1%. Downsizing to three operating rooms is not an option, as Year Two utilization would rise to 68% and a fourth room would have to be added soon thereafter."

   According to Exhibit 10-Supplemental, inpatient and outpatient cases in orthopedic, joint replacement, and fracture surgeries are all expected to begin declining in 2013 and continue declining through 2016, Year 2 after project completion.

   Please discuss as your response and the data in Exhibit 10 don't seem to jive.

   Response:
   I think the confusion lies in our expected transition of consolidating orthopedic cases in the new OR suite on the eighth floor. Currently, the operating rooms used primarily for joint replacement and fracture surgery are not located in a single area and they are undersized. Our goal is eventually to consolidate all orthopedic joint and fracture procedures into the new suite for efficiency and care coordination. We expect to transition approximately 80 percent of the targeted orthopedic cases to the new OR suite in Year One (2015) of the project and about 90 percent in Year Two (2016). This transition projects surgical encounters at 1,417 in Year One and 1,487 in Year Two which reflects increased utilization

of the new rooms in spite of a projected decrease in the total number of orthopedic procedures over time. In addition, our transition projections are based on surgical cases for joint replacement of hips and knees, but we anticipate that physicians will also want to perform shoulder joint replacement surgery in the new space as well. Our intent will certainly be to serve the efficiencies of the surgeons and meet their preferences as much as possible. We have taken a conservative approach to our utilization projections for the new OR suite and these cases have not been included in our transition projections.

A signed affidavit is attached to this letter.

On behalf of Saint Thomas Midtown Hospital f/k/a Baptist Hospital and the entire Saint Thomas Health system, thank you for the opportunity to clarify these points.

Sincerely,

Barbara Houchin
Executive Director, Planning

Attachment

SUPPLEMENTAL- # 2
July 31, 2013
10:41 am

AFFIDAVIT

2013 JUL 31 AM 10 37

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Midtown Hospital f/k/a Baptist Hospital

I, BARBARA HOUCHIN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Barbara Houchin / Executive Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31 day of July, 2013, witness my hand at office in the County of DAVIDSON, State of Tennessee.

Diane Franklin
NOTARY PUBLIC

My commission expires 01/06, 2014.

HF-0043

Revised 7/02

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN.